SERVICES TO SEXUALLY ABUSED CHILDREN AND THEIR FAMILIES

PART IV

PROCESS AND OUTCOME IN THE TREATMENT OF SEXUALLY ABUSED CHILDREN AND THEIR MOTHERS

THE SEXUAL ABUSE TREATMENT PROJECT

Department of Social Services
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Boston, MA 02114

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EXECUTIVE SUMMARY

PROCESS AND OUTCOME IN THE TREATMENT OF SEXUALLY ABUSED CHILDREN AND THEIR MOTHERS

This study was conducted in order to better understand the content and process of therapy with sexually abused children (young children and adolescents) and their mothers and to explore the functioning of the children and their mothers before and after treatment. The sample was comprised of 29 families who were followed through the course of their therapy at specialized sexual abuse treatment programs for a period of up to one year. The focus of the study were "critical moments" in therapy, as identified by the clinicians themselves; these important events were subsequently analyzed according to the topics that were discussed during therapy, the therapist's intervention in response to the topic and the therapist's rationale for making that particular intervention. The analysis of these therapeutic events was intended to address such questions as: how does treatment differ according to the age of the child; what are the differences between therapy with mothers and therapy with victims; and how do group and individual treatment differ for young children and adolescents?

Utilizing the results of a survey of thirty specialized sexual abuse treatment programs (Deveney et al., 1986) which outlined the goals experienced therapists identified in the treatment of victims and their mothers, a series of questionnaires and behavioral inventories were chosen and/or developed to measure aspects of child and adult functioning in areas consistent with the expressed therapeutic goals. The use of these instruments made it possible to explore how therapy differed according to the level of functioning of the victims and their mothers: the scope and quality of mothers' social support network; their capacity for empathy and appropriate role expectations; the victims' sense that they can exert some control over events in their lives and have someone to turn to in times of need.

The measures were administered to victims and their mothers within the first six weeks of treatment, and again after a year or the completion of treatment. They were used to understand the functioning of the individuals, to determine if interrelationships existed between types of functioning, individual characteristics, and between the functioning of the mother and her child. They were also used to determine if relationships existed between individual functioning and aspects of the therapeutic process. Finally, the measures were used to determine if there were differences between individual functioning at the beginning of treatment (pre-test) as compared to functioning at the completion of treatment (post-test).

Characteristics of the Sexually Abused Children and their Mothers

The child and adolescent victims in the study ranged in age from 6-16 years old. Over half the victims were adolescents (12-16 years old). Most victims were exposed to prolonged and serious trauma. Two-thirds of them endured oral, anal and/or vaginal penetration by the offender who, in the majority of cases, was a father figure (biological father, stepfather, mother's live in boyfriend). For one-third of the children beginning treatment, a considerable amount of time (average of 3 years) had passed since the last time they had been abused.

Most of the families in the study were working class and Caucasian. Nearly half of the mothers in the study had themselves been sexually abused as children.

Problems Exhibited by Child and Adolescent Victims

Three-quarters of the children and adolescents in the study were found to have behavioral problems considered to be in the clinical range on a standardized behavior inventory. They turned their problems inward (internalized) and/or acted their problems out (externalized). According to reports by their mothers, many of the child and adolescent victims appeared anxious, sad or withdrawn. Others, however, turned the stress outward engaging in anti-social and sexualized behaviors or being easily distracted.

Behavioral problems were found to be greater in victims who experienced events in their lives as out of control (external locus of control). Factors such as the severity or length of the abuse did not seem to increase a sense of powerlessness for either young children or adolescents.

The extent to which children and adolescents could turn to their mothers for nurturance and support was found to be related to behavioral problems. Younger children who did not feel that they could turn often to their mothers for nurturance and support presented more internalized symptoms, and adolescents evidenced more symptoms of both internalized and externalized types.

Problems Exhibited by Mothers of Sexually Abused Children

While all of the mothers in the study had some social support network, (i.e., at least one person they could turn to for emotional or practical kinds of help), one-quarter of the mothers reported that they had no one to turn to in at least one type of situation. Mothers turned to friends and relatives for practical support more than they did for emotional support. Yet, when asked about the quality of their relationships with friends and relatives, about a third of the mothers did not feel there was equal give and take.

A sizable number of mothers (29%) relied on their children to provide them with emotional support (comfort, encouragement

and confiding). In fact, a majority of the mothers in the sample (54%), tended to hold general expectations that children should attempt to meet their parents' needs. These mothers were more likely to have been sexually abused as children. Additionally, these mothers tended to be those who also reported that they had no one to turn to in various situations for which social support is often given.

A large group (about 40%) of mothers in the study tended to feel that life is determined primarily by factors that are beyond their control. These feelings of external mastery were more prevalent in mothers who themselves were sexually abused as children. Mothers who felt they were in control of life events, turned more frequently to friends and relatives for emotional support.

The great majority of mothers in the sample (78%), demonstrated average or above average empathy toward their children according to a standardized questionnaire. The more empathic mothers tended to have more friends and relatives available for social support.

Relationship between the Functioning of the Child Victim and the Functioning of the Mother

Mothers who felt less control of their lives had young children and adolescents who also felt that events in their lives were out of control. These children were also more anxious, somatic and depressed and were likely to turn to their mothers for support less often than the children of mothers who felt more in control.

Positive aspects of mother's functioning were also seen in the functioning of adolescent children. Empathic mothers had adolescents who felt that they had more ability to control events in their lives. Those adolescents also had fewer behavior problems. When mothers had more appropriate role expectations, their adolescent children tended to have less acting out behavior problems.

Therapy with Child Victims

As might be expected, issues concerning the nature and impact of the sexual abuse are frequent topics in the therapy of child victims. Discussion of sexual abuse was found to take place with much higher frequency in the context of group therapy as compared to individual therapy. Often the subject is initiated as part of a planned exercise by the group leader.

The data suggest that the more time that passes between the last known incident of abuse and the start of treatment, the less likely that sexual abuse as a topic will be part of the critical content of therapy, i.e., the more the topics of conversation will focus on other topics, such as school, family, etc.

In individual therapy, the topic of sexual abuse occurs more frequently in the treatment of younger children than adolescents, particularly in children who have more internalizing symptoms, such as those who appear to be anxious, withdrawn or depressed. In the treatment of adolescents, sexual abuse was discussed more frequently when the adolescents felt less in control over events in their lives.

Protective issues and problems did arise in most of the cases in the study. However, these issues were not frequently identified as critical topics in the therapy of younger children and adolescents. Matters involving safety in the family (parenting skills, drug/alcohol abuse), issues concerning violations of boundaries between family members (living arrangements, privacy) and issues involving system response to the abuse (investigation, placement) constituted a small proportion of all the topics that were reported.

Protective issues were more likely to arise in the individual therapy situation and were more likely to be discussed with younger children who presented more acting out problems.

Mother-daughter conflicts (discipline, lack of trust) and other family matters were more frequent topics of conversation in the therapy of adolescent victims. Therapists discussed family issues more often with young children who did not perceive their mothers to be supportive or nurturing.

Younger children and adolescents alike talked with their therapists about their worries, fears and fantasies. Often these experiences concerned problems of self-image and body integrity.

The most frequent intervention made by therapists in individual and group therapy was an exploration of the victims' perceptions. Such exploration usually involved a request for a description of the younger child's or adolescent's thoughts, feelings, and perceptions about events in their lives.

Therapists intervened in different ways according to the mode of therapy employed. For example, they were much more directive in group therapy but much more supportive in individual therapy with victims. Therapists attempted to structure the therapy (by assigning tasks, using role plays) more often in the context of group therapy. In contrast, therapists offered more support and encouragement to their clients in individual therapy. Support and encouragement was offered more often when the victim had been assaulted by a father figure.

At times, a therapist's intervention consisted of offering information to the client. They offered normative information to victims (i.e., told them about others with similar experiences), and provided information to help correct distorted perceptions.

Interpretive interventions comprised only a small percentage of the critical incidents recorded. Therapists did make these connections between thoughts, feelings and behaviors more often

in their work with adolescents.

It does not appear that therapists often intervene in therapy in order to educate and empower young children and adolescents. Indeed, educative aims (helping the child to understand motivations and behaviors of others) and empowerment goals (helping children develop a sense that they can take charge of situations) comprised fewer than 10% of all the intentions reported by the therapists. The most frequent goal stated was that of furthering the therapist's understanding of the case. Part of this goal was the continuing assessment of protective risk to the children.

Therapy with mothers

In the few cases where mothers were seen regularly, the topics in therapy were quite different from those with young children and adolescents. Mothers talked with their therapists about family and protective issues much more often than did children and their therapists. Most often, protective topics were initiated by the mothers themselves.

Treatment with mothers who did not feel they had control over their lives and/or who held inappropriate role expectations of their children included more material about these women's thoughts and feelings about themselves.

Therapists use structured activities and directed interventions far less often with mothers than with children. With mothers, therapists were more likely to use reflection and confrontation as treatment techniques. As with victims, therapists did not often interpret mothers' thoughts, feelings and behavior.

The treatment goals therapists employed in the therapy with mothers were remarkably similar to those used in the therapy with children. The largest proportion of the interventions made in the therapy of both mothers and children were done with the goal of enhancing the therapist's understanding of the case. This assessment function comprised even a larger portion of the therapy of mothers. Interventions with the goal of improving the relationship between therapist and client (as well as planning for termination, etc.) were less prevalent in the therapy of mothers. All other therapeutic intentions (support, insight, improving functioning, catharsis, education and empowerment) were cited in very similar proportions by therapists of mothers and children. As with children, the goal of empowerment and mastery was relatively infrequent.

Child and Adult Functioning at Post-test

The children and adolescent victims who participated in this study showed a significant reduction in their behavioral symptoms during the period of time their treatment was followed for this study, as measured by a standardized behavior inventory, and a

behavior checklist filled out by therapists. There was no significant change in the victims' sense of control over events in their lives during the study period. While no significant increase was seen in the ability of the victim to turn to her mother for nurturance and support, there was a tendency toward an overall increase in the availability of support to the child.

A significant improvement took place in the level of role reversal by the mothers who participated in the study, as measured by two methods. No changes, however, were found regarding the mothers' sense of mastery, empathy for the child, nor in their social support network.

Many fewer changes were observed between administrations of the pre- and post-tests than were anticipated. The absence of changes on the locus of control and mastery studies may be the result of several possible factors, which are discussed in Chapter Five.

Implications for Treatment

The findings suggest it is important to treat mothers as well as child victims. As mothers developed more appropriate role expectations of their children, children's behavioral symptomatolgy decreased. The analysis of "critical event" data also reveal the importance of group treatment as a modality for victims in addressing issues arising from the sexual abuse.

Finally, the analysis indicates that although therapists espouse mastery and empowerment as primary treatment goals, they are not always able to implement those goals, at least in the first year of therapy where the focus is more often directed towards assessing protective issues, and monitoring other risk factors such as: alcohol/drug abuse, neglect, physical/verbal violence. An important implication for referral is that the more time that lapses between the last incident of sexual abuse and the onset of therapy, the less sexual abuse is dealt with directly in the therapy.

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CHAPTER I: OVERVIEW OF THE STUDY

INTRODUCTION

Recently, after reviewing published and unpublished reports of clinical work with sexually abused children and their families, Thomlinson (1988) concluded that there was a paucity of empirical research on treatment outcomes. He also noted that there were few studies that have investigated, in any systematic way, process variables that might account for treatment success. "Little if anything has been done" Thomlinson writes, "to factor out who does what to whom, and with what criteria." (p.2)

Most of the research in the field, in fact, consists of largely anecdotal case studies or descriptions of treatment programs. It is clear from these reports that clinicians employ a variety of treatment techniques and modalities in their work with sexually abused children and their families. In a recent survey of more than five hundred sexual abuse treatment programs, for example, Ciccinelli, Keller and Gardner (1987), observed that therapists used individual, group, and family therapy approaches and employed a "broad mix of specific techniques, including insight therapy, play therapy, behavior modification, and a variety of educational approaches, such as psychoeducation, skills training... and cognitive restructuring." (p.6) Very few studies, however, have attempted to describe the context of these interventions (how they are used, with whom, and under what circumstances) or assess their effectiveness.

The purpose of this study is to describe the process and outcomes of therapy with sexually abused children and their

mothers. Historically, process (what happens in therapy sessions) and outcome (changes that occur) have been seen as separate domains of psychotherapy research. More recently, however, these traditions have begun to merge, as researchers recognized the value of specifying the basic mechanisms of therapy in relation to client changes over time (Greenberg & Pinsoff, 1986).

THERAPY PROCESS

Psychotherapy process research has been criticized for failing to recognize decisive moments in therapy, where there is significant opportunity for change, and where interventions may be particularly helpful or harmful (Elliot, 1983). Recently, attempts have been made to isolate and examine "critical events" in psychotherapy sessions. For example, Elliot et al. (1985) found associations between therapist responses (such as self-disclosure or interpretation) and client perceptions of helpful moments (realizing something new about oneself, feeling motivated, etc.) in adult outpatients. From that study, Elliot (p.267) concluded that "different techniques (response modes) operate to accomplish the same therapeutic tasks in different helping situations." Along the same lines, Mahrer and Nadler (1986) developed a provisional list of "good moments" in therapy -- occasions when clients manifested progress, movement, or change. They suggested that these moments may have defined stages or phases -- configurations that are either unique or common to various presenting problems and therapeutic approaches.

In the current study, therapists were asked to describe critical in-session events in the therapy of child victims and

their mothers. For purposes of the study, a "critical event" was defined as a therapist's subjective appraisal of an important moment in a particular therapy session. The critical event describes a therapeutic interaction or exchange, consisting of (1) a specific topic, or subject of discussion, initiated by either the therapist or the client; (2) a specific intervention - the therapist's activity in relation to the topic of discussion; and (3) an intention - the therapist's purpose, or rationale for making a particular intervention.

The collection and analysis of critical event data were framed by four goals:

(1) To identify patterns of critical events for different samples of sexually abused children and their mothers, allowing us to answer such questions as: how does the therapy differ with latency age victims vs. adolescent victims; with severely vs. less severely abused children; with mothers who were themselves sexually abused vs. those who were not?

(2) To identify sequences or stages in the treatment of sexually abused children and their mothers, i.e., differences in topics, activities, and therapist intentions in the beginning, intermediate, and termination phases of treatment.

(3) To identify associations, where possible, between critical events and various treatment objectives or outcomes for children and mothers. For example, did the therapy of children who showed a reduction in "externalized" (acting out) symptoms differ from the therapy of those children who did not show a reduction in those symptoms?

THERAPY OUTCOMES

As Thomlinson (1988) points out, outcome research in child sexual abuse is difficult for at least three reasons: (1) victims do not present with the same problems; they exhibit a broad range of symptomatology and differ with respect to severity of the abuse, family dynamics, and responses to the disclosure; (2) there are few measures available that are specific to the problem of child sexual abuse; and (3) child victims are a special group, and researchers "must be overly cautious in ensuring that they do not compound the client's trauma in their efforts to collect data" (p.16). In this study, outcome measures were selected with those criteria in mind: basically, we sought instruments that measured constructs identified as important by experienced clinicians working in the field, and that were relatively non-intrusive (i.e., brief administration and no direct references to sexual abuse).

During a survey of thirty specialized sexual abuse treatment programs conducted in 1986, (Deveney, Edbril, Rintell & Katzman), senior clinicians were interviewed about the responses of mothers and victimized children to abuse, frequently observed problems, and their objectives in treating mothers and children. In addition, five other therapists with lengthy experience (averaging eight years) and recognized expertise in sexual abuse treatment were interviewed and asked to identify common issues and themes in clinical work with victimized children and their mothers (Deveney, 1986). The constructs that underlie the outcome measures used in this study were derived from the following interview data:

Victims

(1) The behavioral manifestations of sexual abuse depend on many factors, including the age of the child, the nature of the offense, and the response of the non-offending parent and other adults after the disclosure of the abuse. Often, the effects of the trauma are exhibited in physical symptoms (enuresis, eating disorders, etc.) and somatic complaints. Some children and adolescents act out their problems in fighting, drug and alcohol abuse, suicidal behavior, etc., while others internalize their responses, and become fearful, anxious, and/or withdrawn. Young children may exhibit sexualized behaviors that are atypical for their age, such as sexualized play (with toys, playmates, and animals), excessive masturbation, and provocative behavior with adults. Some children may not exhibit any overt signs of trauma.

(2) Victimized children often feel that they are powerless over events in their lives. One of the primary treatment objectives with sexually abused children is to develop a sense of personal empowerment, i.e., to help them see that they are capable of affecting change with people and events in their environment.

(3) Sexually abused children, who have been betrayed by an adult caretaker, often find it difficult to trust and form alliances with adults. All children, however, need to be able to turn to adults for support. It is particularly important that sexually victimized children have a strongly supportive adult (ideally, their mother) who is available to them: someone who believes them; someone they can tell things to; someone, who as one therapist put it, will "celebrate the good and sympathize with the bad."

Mothers

(1) Mothers of victims also often need to develop a sense of mastery or control over their lives. According to the therapists, about half of the mothers they see in treatment were themselves victimized as children (Deveney, et al, 1986), and so experienced the powerlessness that their children now feel. Additionally, many mothers have been further victimized by abusive husbands or partners, or are members of patriarchal and/or autocratically organized families, where rules are rigid and strictly enforced, roles are stereotyped, and differences cannot be discussed.

(2) According to the therapists, many of the mothers of child victims feel socially isolated and have limited social support resources. These mothers often feel that others are not capable of helping them with their troubles and concerns and they are reluctant to turn to friends, professionals, or

family members for advice, encouragement, or help with practical problems.

(3) Mothers who are best able to help their children cope with the trauma of sexual abuse are probably those who are emotionally sensitive to the child's needs. Mothers who are able to empathize with their children are more likely to take appropriate action on behalf of the child and to demonstrate care and concern.

Family Functioning

(1) Many of the children seen in therapy have been forced to assume adult roles within the family, and thus present a facade of "pseudomaturity." In these families, children are perceived as objects for adult gratification and are accepted only to the extent that they help make their caretakers' lives easier.

(2) Family dysfunction, while not etiologically responsible for sexual abuse, is often an impediment to change. The therapists who were interviewed noted that there are often many structural dysfunctions in families where sexual abuse has occurred; relationships between family members, for example, may be overly distant or overly close. Some families may respond to situational stress in a rigid and inflexible way.

The propositions that underlie the outcome component of the study thus involve the issues of mastery and control, nurturance, social support, family roles and and symptomatic response to trauma.

METHODOLOGY

The sample was composed of 29 families in which at least one child had been sexually abused, and was receiving treatment at a specialized sexual abuse treatment program. Three treatment programs were located in mental health centers, two in hospitals, and one in a social service agency. In all, 35 children and 24 mothers participated. The children ranged in age from 6 to 16 years (mean = 12.5). Of the sample, 32 were girls and 3 were boys. The mothers ranged in age from 25 to 42 years (mean = 35).

The offenders in these cases were all male relatives, mothers' boyfriends, or male non-family members.

Families were recruited into the study by therapists at the start of treatment. The criteria for inclusion (Appendix A) required that a child be between the ages of six and sixteen and sexually abused by a caretaking male. While the inclusion criteria were objective, the therapists in the participating treatment programs exercised their discretion when deciding whether or not to ask mothers to participate in the study. Although no information is available on families that met the inclusion criteria but were not recruited by therapists, it is assumed that families in crisis were not approached. Other subjective reasons for non-recruitment are also assumed to have taken place. The findings of this study are therefore limited to the sample.

Participation in the study required an informed consent from the child's non-offending parent or custodian and assent from children over age 14. After obtaining consent, child subjects were administered the following instruments as pre-tests: (1) the Bialer Locus of Control Scale and (2) the Nurturance Scale. Adult subjects were administered: (1) the Social Network Questionnaire; (2) the Network Orientation Scale; (3) the Pearlin Mastery Scale; (4) the Adolescent-Adult Parenting Inventory (AAPI) and (5) the Child Behavior Checklist (CBCL). In addition, the therapists and case managers from the Department of Social Services completed Problem Checklists on each child and mother at the start of treatment. The instruments are described in greater detail in Chapter II.

All instruments were administered again one year after the start of treatment, or when the client terminated, whichever came first.

Data regarding psychotherapeutic treatment was collected in the following way: twenty-seven therapists who provided individual and group therapy to the children and/or mothers in the study were interviewed each month by the researchers (two social workers and a psychologist) and were asked to identify critical moments in their last therapy sessions with children and/or their mothers. A standardized recording form was used to record each interview (Appendix B). Each critical event was then coded according to the topic of the critical event, the nature of the therapist's activity with regard to the topic, and the therapist's intention in intervening in that particular way. The classification scheme was drawn from various taxonomies of therapist behaviors and purposes (Orlinsky & Howard, 1978; Cooke & Kipnis, 1980; Hill & O'Grady, 1985; Elliot, James, Reimschuessel, Cislo & Sack, 1985), and may be found in Appendix C. The final coding system consisted of seven topic categories, eight activities, and eight intentions. In all, nine hundred and twenty-one critical events were collected and analyzed in the course of the study.

In order to establish the reliability of the Critical Event Measure (CEM), thirty events were coded by the researchers and assigned codes were compared. Inter-rater reliability was computed separately for topics, activities, and intentions, using Cohen's Kappa (1960). The agreement rate for the three raters was as follows: Topics r=.86, Activities r=.83, Intentions r=.82.

The validity of the CEM was established in the following way: three expert judges (highly experienced sexual abuse clinicians not involved in the study) rated the adequacy of the definitions of the coding categories and the extent to which they agreed with the researchers' assignments of topics, activities, and intentions in a random sample of ten cases. The experts rated the categories as highly comprehensive, generally fitting with their prior understanding of each construct, and agreed with their application to the therapy material. In an effort to establish construct validity, the judges were also asked to classify topics, activities, and intentions in a random sample of thirty events. The expert judges, with minimal training, achieved a moderately high level of inter-rater agreement (Topics r=.74, Activities r=.72 and Intentions r=.71). When the coding by judges was compared to that of the researchers, the level of agreement was also relatively high (Topics r=.79, Activities r=.64 and Intentions r=.74) which suggests that this coding methodology is valid and replicable. A more complete description of the validity study may be found in Appendix D.

The therapists who participated in the study were a varied group with regard to age, experience, and background. A third had three or fewer years of post-graduate experience, while one therapist had thirty years of experience. All but one of the therapists had had specialized sexual abuse training. The average age of the therapists was thirty-five; they ranged from 26 to 52 years old. Ten held MSW degrees, five had Masters in psychology or counseling, and one was a social work student who had a Bachelor's degree.

When therapists were asked to name the theoretical perspective that most influenced them, they were evenly distributed between psychoanalytic theory, behaviorism, cognitive theory, family systems, self-psychology, and object relations theory.

CHARACTERISTICS OF THE SAMPLE

The "average" profile of a child in the sample was one who was 12.5 years of age at the onset of treatment and first abused at age eight. Over half (57%) of the children in the sample were between the ages of 12 and 16 at the start of treatment, and more than a quarter (29%) of the group were under age 5 when the abuse began.

There is little doubt that the children were exposed to prolonged and serious trauma. Two-thirds of the group endured oral, anal and/or vaginal penetration by the offender. Most of the children were exposed to more than one type of sexual abuse (mean = 2.5 types). On average, the abuse lasted two and a half years. In cases where the information was known (half the sample), one-half of the children had experienced abuse on a weekly basis.

For two-thirds (61%) of the victims, there was no time lapse between the last known incident of sexual abuse and the disclosure of the abuse/start of treatment. Others (39%), however, who experienced abuse in the past did not disclose their abuse and begin treatment until long after the abuse had ended (mean = 3 years).

For the most part, the families in the study were working

class. Eighty-eight percent of the mothers were either unemployed, or employed in unskilled, semiskilled, skilled, clerical or sales positions. Employment data on the offenders were not available. Family income averaged $23,100 and 70% of the families had incomes less than that average amount. Most of the mothers had a high school education or less.

Nearly half (48%) of the mothers in the study reported a history of sexual abuse.

The offender in the majority of cases (70%) was a "father figure" (biological father, stepfather, mother's live-in boyfriend). Most often (39% of the cases) the offender was the child's biological father. Other relatives comprised 15% of the offenders, while 15% were non-family members.

More detailed demographic data pertaining to the sample may be found in Appendix E.

CHAPTER II: FUNCTIONING OF SEXUALLY ABUSED CHILDREN AND THEIR MOTHERS AT PRETESTING

A. SEXUALLY ABUSED CHILDREN

The following section describes the status of the child victims at the time they entered the study with regard to three measures of child functioning: behavioral symptoms, locus of control, and turning to others for nurturance and support. Each of the measures were analyzed with respect to characteristics of the abuse history of each child and the age of the child. For the purpose of understanding the effects of age on locus of control, nurturance, and symptomatology, the children were divided into two groups: ages 6 to 11 (referred to as "younger children") and ages 12 through 16 (referred to as "adolescents"). The relationships between the children's scores on the three measures are also discussed at the end of the section.

Since the sample included some families in which more than one child participated in the study, it was necessary to reduce the sample to one consisting of one child per family in order to avoid the difficulties of an intercorrelated sample. In eight cases, children were randomly selected and removed from the sample. The analyses that follow were performed with a sample of 27 children, with no siblings included.

1. BEHAVIORAL SYMPTOMS

When therapists were asked to talk about symptoms they observed during therapy with sexually abused children, they described a wide range of attitudes and behaviors. Their descriptions concur with an extensive clinical literature on the

topic, which suggests that the effects of sexual abuse on children are many and varied.

(a) The Child Behavior Checklist

The parent's version of the Child Behavior Checklist or CBCL (Achenbach and Edelbrock, 1983) was selected for use in the present study because the instrument measures a range of behaviors, has been used before in studies of sexually abused children, and has well-established reliability and validity.

The CBCL relies on parental appraisal of children's behavior. The items on the CBCL cluster around two broad-band factors: internalizing symptoms and externalizing symptoms. Internalizing symptoms are those that indicate a turning inward of stress (anxiety, withdrawal, depression, somatic complaints, etc.). Externalizing symptoms are those that turn stress outward (aggression, hyperactivity, delinquency, etc.). Parents (mothers in this study) were asked to rate each item on the CBCL on a three point scale, indicating how true each problem was for their child at the time of administration or within the past six months. The CBCL provides a total behavior problem score, an internalizing symptom score, and an externalizing symptom score.

The CBCL also yields a social competence score, which provides information about the child's activities, social relations and school performance.

Findings pertaining to the Child Behavior Checklist:

Three quarters of the children and adolescents in the sample have behavior problems that place them in the clinical range (at or above the 90th percentile). Norms for the clinical range were derived from samples of children and

adolescents who were in treatment at outpatient mental health clinics.

Internalized problems were slightly more prevalent in the sample than externalized problems; 61% of the victims had internalized problems in the clinical range; 52% had externalized problems in the range. The internalizing and externalizing symptom scores for the adolescents in the study were found to be highly correlated ($r=.79$, $p<.001$). This indicates that the adolescents exhibited both internalizing and externalizing symptoms in response to the sexual abuse.

Most victims did not show extreme problems in the area of social competence; thirty-one percent of the sample fell into the clinical range of the social competence sub-scale, which indicates that about two-thirds of the group participated in school and social activities about as much as their peers.

Several studies have identified severity factors in sexual abuse that contribute to increased trauma for the victims (Conte & Schuerman, 1985; Browne & Finkelhor, 1985). Two such factors are duration and relationship to offender. It has been suggested that the longer the duration of the abuse and/or the closer the relationship between the victim and offender, the greater the risk for more severe types of trauma.

Contrary to these findings, the results from the CBCL in the present study indicated that victims demonstrated fewer problems when the offender was a father figure than when the offender was another relative or caretaker ($F=6.63$, $p < .002$). Also, when the offender was a father-figure and the abuse continued for a longer time, children and adolescents exhibited less symptomatology ($r= -.65$, $p<.05$).

These findings raise questions about whether children abused by a father figure and who have endured a longer history of abuse, actually experienced less trauma, or if mothers were inaccurate reporters of their children's behavior. In cases where the offender is mother's partner, mothers may have denied

problems with their children or minimized the impact of the abuse, in order to maintain/justify relationships with the offenders, Another consideration is that some children may mask their distress by functioning well behaviorally and socially out of fear of being blamed or abandoned by the non-offending parent or perhaps to compensate for low esteem.

(b) The Sexual Abuse Symptom Checklist

The Sexual Abuse Symptom Checklist (SASC) was developed specifically for this study, for two major reasons. First, a review of the literature revealed that of the instruments available to study child behavior and symptomatology, none focused specifically on the symptoms seen in children who have been sexually abused. It seemed important to be able to determine what sexual-abuse related symptoms were experienced by each child and adolescent in the present study. Second, while self-report and parental report measures of child functioning were available, we considered it important to obtain the therapist's report on the behavioral symptoms experienced by their clients. Therefore, a therapist-report, sexual-abuse specific checklist was developed in the following manner:

In telephone interviews, six clinical experts in the field of sexual abuse were asked to provide a description of the symptoms and responses they have seen most often in children who have been sexually abused. The reports of the experts were converted to a 117 item checklist, which utilized the CBCL's three point scale (0 if not present, 1 if sometimes true for the child, 2 if often true).

Findings pertaining to the Sexual Abuse Symptom Checklist

There was a wide range of scores on the SASC in this population of children and adolescents. The scores ranged from 16 to 133 with a mean of 54.6. The scores on the SASC did not appear to be affected by such variables as the social distance to the offender, age of the child, duration and severity of the abuse. The items which were reported to be true for the largest number of children were as follows:

Isolated, feels different from others	92%
Feels shame	83%
Presents facade of well-being	79%
Feels vulnerable	79%

Virtually all of the 117 items on the SASC were endorsed for at least one child, yet the wide range of scores seems to suggest once again that there is no specific pattern of response to sexually abuse. The lack of significant relationships with important background variables such as severity and identity of offender also suggests that an individual child's response to the abuse is multi-determined, and influences on that response are hard to pinpoint.

2. LOCUS OF CONTROL

Clinicians often describe sexual abuse as an abuse of power. They argue that when offenders feel overwhelmed or inadequate they gravitate toward children, who are more helpless and vulnerable than they, in order to experience a sense of control. As a result of this dynamic, therapists find that children who passively submit to the abuse and those who may have resisted the abuse but also were coerced, manipulated, or threatened by an adult are usually left with feeling disempowered and that events can never be contingent upon their own actions. Consequently,

therapists say that a key treatment goal is to help children feel that they can, to some extent, exert control over things that happen to them.

Belle's (1979) 19 item version of the Children's Locus of Control Scale (Bialer, 1961; 23 original items) was chosen for inclusion in this study because it measures the extent to which children perceive events in their lives as being within their control. The scores on the Belle version of the CLCS range from 19 to 38; scores on the higher end of the scale suggest an external locus of control, i.e respondents experience events as beyond their control. Lower scores suggest an internal locus of control, i.e. respondents feel capable of affecting change in their environments. Examples of items include (1)"Can you ever make other people do things you want them to?"; and (2) "When people are mean to you, is it because of something you did?"

Findings pertaining to locus of control

> The age of the victim and his/her sense of control over events in his/her life were found to be related; adolescents had more internal locus of control than younger children, i.e. they felt more in control of events in their lives ($F = 11.23$ $p<.005$).

This finding was expectable and consistent with results from other locus of control studies (Milgram, 1971; Nowicki & Strickland, 1978). The movement towards internality is viewed as concomitant with the child's growing cognitive abilities (Bachrach, Huesmann & Peterson, 1977) and reflective of the adolescent's increasing independence from parental influence and environmental exploration (Gilmor, 1978).

No significant relationships were found between locus of control and the characteristics of the abuse (duration, penetration, offender category).

This lack of association between locus of control and severity factors is curious. For those children who were exposed to more severe forms of abuse (longer duration; offender was a father figure; penetration), one might expect them to feel significantly less control over events in their lives. Browne and Finkelhor (1985) suggest that a child's sense of powerlessness results from repeated bodily invasion and inability to stop the abuse. Absence of a finding therefore, might indicate problems with the locus of control measure, the small sample size or possibly the theory itself.

3. NURTURANCE AND SUPPORT

Most of the clinical literature on incestuous families suggest that a breakdown exists in the mother-child relationship which significantly affects a child's perception of his/her mother as available to help prevent and cope with an abusive situation. When sexual abuse has involved betrayal by an adult caretaker, it is not uncommon for a child to experience difficulty trusting a parent and turning to them for support and nurturance. Yet the support of a parent has been shown to protect against as well as to help mediate the negative effects of trauma in a child's life (Rutter, 1979). Information from both the literature and therapist interviews (Deveney et al., 1987) raises the question of whether sexually abused children have people to turn to for support, notably mother, who comprise

their support network; and how often and under what circumstances do they seek support from parents, other adults and/or peers.

In order to measure the victim's social support, the Child's Nurturance Scale was adapted from Saunder's Nurturance Questionnaire (1979). It was chosen for its simplicity and brief administration. The questionnaire asks the child directly to whom s/he would turn to talk about feelings and important events or in times of need. An example of an item on the questionnaire is: "When you do not feel good, when you are upset or unhappy, whom do you want to be with?" One question was added to Saunder's nine item scale: "Who would believe you even when you tell them something that is hard for them to believe"?. Children respond to each question with one or more names of people they would turn to, or they could respond that they turn to no one. Scores were then calculated by totaling the number of times a child mentioned turning to mothers, friends and no one.

Findings pertaining to nurturance and support

> While younger children and adolescents turned to mothers for support and nurturance, younger children did so more than twice as much as adolescents. ($F=17.04$, $p<.001$). Conversely, adolescents turned to their friends for support significantly more than younger children ($F= 5.12$, $p<.05$), and tended to turn to friends more than they turned to mothers. About the same proportion of adolescents as younger children reported having no one to whom they could turn.

These findings are expectable and age appropriate given the developmental tasks of adolescent and latency age children.

4. RELATIONSHIP BETWEEN PERCEPTIONS OF LOCUS OF CONTROL AND NURTURANCE AND OBSERVABLE BEHAVIORAL SYMPTOMS

Locus of control and nurturance both involve self-perceptions. They are processes that go on inside a child, and are not seen by outside observers. The Child Behavior Checklist, on the other hand, consists solely of observable overt behaviors, excluding feeling states of a child's self-perception. What is the relationship between these inward states and observable behavioral symptoms? How might, for example, children with external locus of control (the feeling that events in one's life are beyond one's control) look on the CBCL? Would they have more symptoms?

By doing a correlational analysis, a number of relationships were found between locus of control, nurturance, and behavioral symptoms. In order to present these relationships clearly, younger children and adolescents were considered separately, since age differences have been shown to affect the scores on the Bialer Locus of Control Scale and the Nurturance Questionnaire. The correlations can be found in Table I.

> Locus of Control, as measured by Bialer scale, was found to be related to child symptomatology. These relationships were different with respect to adolescents and younger children. In adolescents, the relationship seems straightforward and expectable. The more adolescents felt that they could not control events in their lives, the more symptoms they exhibited, both internalizing (r=.74) and externalizing (r=.81).
>
> In younger children, the effect of locus of control was more complex. External locus of control was associated with internalizing symptoms. The more younger children felt that they could not control events in their lives, the more they exhibited internalizing symptoms, such as depression, withdrawal, and somatization (r=.45). Conversely, internal locus of control was associated with externalizing symptoms. Children who felt more in control over events in their lives

exhibited more externalizing symptoms, such as delinquency, aggression, and hyperactivity (r=-.57).

In adolescents, then, the feeling that events in one's life were beyond one's control resulted in both internalizing and externalizing symptoms. For younger children, it seems that feeling out of control was more associated with the turning inward of stress. Yet, when younger children reported feeling more in control, it did not alleviate the stress for them as much as for adolescents. It may be that sexually abused children who feel like events are relatively under their control still experience anxiety, and the feeling of control does not mitigate this anxiety, which is expressed outwardly.

A child's expressed ability to turn to others for nurturance was also found to be related to behavioral symptomatology. Again, the relationship was very different for adolescents and younger children. In adolescents, the less they were able to turn to their mothers, the more symptoms were reported on the CBCL (r=-.56). However, for younger children, the more they turned to their mothers for nurturance and support, the higher their internalizing symptoms as reported on the CBCL (r=.58). In contrast, the more younger children were able to turn to friends, the lower their internalizing symptom score on the CBCL (r=-.51).

In order to understand these findings, it may be helpful to examine the relationship between nurturance and locus of control.

Younger children, who reported their lives as more out of control, experienced more depressive symptoms and turned more often to their mothers for support (r=.49).

One possible explanation may be that depressive type symptoms interfere with friendships and the ability of a child to share with their friends. On the other hand, the availability of friends as confidants may help reduce a child's depressive reaction to the abuse.

The relationship between locus of control and confiding in mothers for nurturance was again quite different for adolescents and younger children.

> The more adolescents reported that they were able to turn to their mother, the more internal their locus of control (r=-.58). Additionally, the more adolescents reported that they had someone to turn to, the more control they felt over their lives (r=.43).

These results suggest that a more straightforward relationship exists between locus of control, nurturance, and symptomatology for adolescents than for younger children. The effects of development would of course be important factors here, as well as any differences which may exist in the ways that younger children and adolescents experience their abusive situations.

TABLE I

INTERRELATIONSHIPS BETWEEN CHILD MEASURES

	CBCL: INTERNALIZING[1]		CBCL: EXTERNALIZING	
	Younger Children	Adolescents	Younger Children	Adolescents
Locus of Control[2]	.45 *	.74 ***	-.57 *	.81 ***
Nurturance[3]:				
Turning to Mother	.58 **	-.56 **	.06	-.45 *
Turning to Friend	-.51 *	-.17	.35	-.37
Turning to No One	.13	.19	.38	.54 *

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LOCUS OF CONTROL

	Younger Children	Adolescents
Nurturance:		
Turning to Mother	.49 **	-.58 ***
Turning to Friend	-.81 ***	-.03
Turning to No One	-.30	.43 **

* p < .05
** p < .01
*** p < .005

[1] Higher scores reflect more symptomatology

[2] Higher scores reflect more external locus of control

[3] Higher scores reflect greater use of confidant

B. MOTHERS OF SEXUALLY ABUSED CHILDREN

Three questionnaires were administered to the mothers of sexual abuse victims at the time of pretest. In the section which follows, the scores on the measures are discussed with regard to individual and family characteristics. Relationships between the measures are then explored.

1. SOCIAL SUPPORT

Although the data are largely anecdotal, studies have repeatedly suggested that child maltreatment is more likely to occur when families are socially isolated (Garabino and Crouter, 1978; Maidman, 1984).

Support systems are obviously important for individuals who are experiencing stress; family and friends can provide comfort, advice, and concrete help with tasks during periods of crisis (Gottlieb, 1981). Recently, a study comparing mothers of abused and non-abused children (Wald, Carlsmith & Leiderman, 1988) found that mothers of abused children were much less likely to have neighbors they could talk to regularly or friends they could depend on in times of need. In terms of sexual abuse, clinical reports of intrafamilial abuse frequently describe the closed or "embedded" features of life in these families, which may serve to maintain the family "secret," but which may also have the effect of cutting off family members from potential sources of outside support.

In this study, we used two measures to examine social support, the Social Network Questionnaire and the Network Orientation Scale.

The Social Network Questionnaire (SNQ) yields two types of measures of mother's social support network: the occasions of use (extent to which mothers turn to friends, spouse/partners, children, relatives and professionals in various circumstances) and the size (number of people in the network) for each of the following kinds of social support: socializing, emotional support, advice/guidance and instrumental support (practical and financial assistance). The occasions of use score is measured by a 15 item questionnaire, drawn from two sources: the Measure of Social Support Resources (Vaux and Harrison, 1985), and the Inventory of Socially Supportive Behaviors (Barrera, 1981). Sample items from the SNQ include the following: (1) "Who would you confide in when you need to talk about personal and private things?" and (2) "Who would help you weigh your choices and options when you need to make a decision?" A count is made of the number of times the mother mentioned each source (friend, relative, professional, spouse/partner, child, and no one) of social support. Scores for each source range from 0-15. Subscores were also calculated for each type of social support (socializing, emotional, advice/guidance, and instrumental).

Network size scores are derived for each type of social support by asking the respondents how many different people would they turn to in each category (friend, relative, professional).

The SNQ also uses Vaux's concept of "balance" in supportive relationships to measure (in two questions) the extent to which mothers feel there is reciprocity, or "give and take," in their relationships with friends and relatives.

The Network Orientation Scale (NOS) is a twenty item test

that measures both an individual's willingness to utilize support resources during times of need and the extent to which the person holds expectations or beliefs that it is "inadvisable, impossible, useless, or potentially dangerous to draw on network resources" (Vaux, Burda & Stewart, 1986). Normative data on the NOS are not yet available (Vaux, personal communication), although network orientation has been found to be "consistently and significantly related to the availability of specific supportive behaviors...both from family and friends" (p.13). Sample items from the NOS include the following: (1) "You have to be careful who you tell personal things to;" and (2) "Friends often have good advice to give you."

Findings pertaining to social support:

On the average, mothers had about four friends and four relatives upon whom they could rely for recreational support, and about 3 friends and 2 relatives to whom they turned for instrumental support (i.e., borrowing, help with child care). Mothers identified fewer friends and relatives upon whom they could rely for affective support (comfort and confiding) and informational support.

All of the mothers reported that they could turn to a friend on at least one occasion, or a relative on at least one occasion, for some kind of social support. Friends provided more recreational support than the other kinds of social support. Relatives were turned to for support more often for instrumental reasons (borrowing, etc.). Most (80%) of the mothers reported that they could rely upon a professional (therapist, caseworker, clergy, or physician) in at least one instance. When professionals were turned to, it was mostly for emotional and informational support. Overall, however, turning to professionals for support was much less frequent than turning to relatives and friends. While most (70%) of the mothers turned to their children for some kind of social support, only 29% relied on their children to provide them with emotional support (comfort, encouragement, or confiding). When children were used for social support, it was most often for recreational support. Some mothers (22%) responded that they had no one to turn to on at least one out of the 15 situations posed.

Mothers of incest victims are often described as socially and physically isolated from the community and having few people to turn to for support (Haugaard & Reppucci, 1988). Although the findings of this study can neither support nor negate this hypothesis without a comparison group of mothers from non-incestuous families, it is striking to note that one-quarter of mothers reported that they had no one to turn to in at least one social situation.

Social support was not found to be significantly related to mother's history, education or income.

About a third of the mothers reported that they give more than they get from their relationships with friends and relatives, and half felt there was an equal give-and-take.

The Network Orientation Scale is thought to measure a person's expectation that turning to others for social support will be useful. There was a very wide range of scores on this measure in this sample of mothers, from very positive expectations to very negative in their attitude toward the help others can provide to them.

Network orientation was found to be significantly related to a number of other factors in social support:

Mothers with more positive expectations of the benefits of social interaction turned to friends more often for affective ($r= -.45$, $p<.01$) and informational ($r= -.37$, $p<.05$) social support.

Mothers with negative expectations for utilizing support resources more often reported that they had no one to turn to for all kinds of social support ($r= .49$, $p<.01$).

Expectations of social support were found to be associated with the number of relatives relied upon for all types of support: The more positive the expectation, the more relatives turned to for support ($r= -.40$, $p<.05$).

Network orientation was found to be associated with the number of friends relied upon for affective, instrumental, and informational social support: The more positive the attitude about social support, the more friends who were turned to for those kinds of support ($r= -.31$, $p<.10$).

2. MASTERY

According to the therapists who were interviewed as part of our survey of sexual abuse treatment programs (Deveney et al., 1987), a primary objective in the treatment of mothers of child victims is to help them see that they are capable of taking control over their lives. Therapists alternately described this goal as "empowerment," "increased self esteem," and "mastery."

The Pearlin Mastery Scale was chosen for inclusion in the current study because it measures the extent to which people see themselves as being in control of important forces that affect their lives. Thus, the scale is concerned with a person's perceived ability to deal with his/her problems, regardless of their source. Mastery has been described as a dimension of self-concept, and has been found to be significantly related to measures of self esteem (Pearlin, Menaghan, Lieberman & Mullan, 1981).

The seven item Mastery Scale was developed from a factor analysis of a series of open-ended interviews with adults, which focused on coping skills and life stresses. Lower scores on the scale indicate internal locus of control (the sense that one is in control of one's life); higher scores denote external locus of control (the feeling that life is beyond one's control). Sample items from the Mastery Scale (which respondents rated on a four point scale, ranging from strongly agree to strongly disagree) include the following: (1) "There is really no way I can solve some of the problems I have;" and (2) "I have little control over the things that happen to me."

Findings pertaining to Mastery

About 40% of the mothers in the sample scored at the medium high to high end of the Mastery scale, suggesting (according to Pearlin's scoring) that they tend to believe that life is determined primarily by factors that are beyond their control.

Mothers in the sample who were themselves sexually abused as children felt less in control of their lives than mothers who were not sexually abused as children ($F=3.20$ $p<.10$).

This finding may suggest that the chaos and trauma following disclosure might be exacerbated for mothers with histories of sexual victimization, as it can recapitulate painful feelings of powerlessness from their own childhood abuse. Consequently, the compounding of feelings about their child's abuse and their own, may contribute to a decreased sense of control.

3. BEHAVIORAL SYMPTOMS

As in the case of child symptomatology, no instrument was found which provided a measure of an adult's behavioral response to the sexual abuse of her child. The Adult Symptom Checklist was developed for this study by the same means as the Sexual Abuse Symptom Checklist: In telephone interviews, six clinical experts in the field of sexual abuse were asked to provide a description of the symptoms and responses they have seen most often in the mothers of children who have been sexually abused. The reports of the experts were converted to a 35 item checklist, which utilized a three point scale (0 if not present, 1 if sometimes true for the child, 2 if often true). The Adult Symptom Checklist was filled out by each mother's therapist.

Findings Pertaining to the Adult Symptom Checklist

The scores ranged from 12 to 40, with a mean of 25 items endorsed. The items most frequently endorsed were as follows:

Feels guilt and/or responsibility for not protecting the child	89%
Feels inadequate as a mother	89%
Feels helpless in dealing with life's problems	89%
Feels guilt and/or responsibility that the abuse occurred	83%

4. PARENTING: EMPATHY AND ROLE REVERSAL

Although very few of the therapists who were interviewed in the survey of sexual abuse treatment programs (Deveney et al., 1987) felt that mothers actively collude in the sexual abuse of their children, many felt that the problem was often exacerbated by the poor quality of the relationship between the mother and the child victim. They reported impairment in the mother's ability to respond sensitively to the emotional and psychological needs of the child. Where therapists noted that helping parents learn more about their children was an important treatment goal, the development of empathy was usually regarded as a critical part of that process.

Many of the therapists also cited role reversal as an important family dynamic in sexual abuse cases. More than half of the respondents reported that they "frequently" saw "parentified" child victims, who were expected to both provide emotional nurturance to their parents, particularly their mothers and assume adult task functions (cooking, laundry, child care). A goal of treatment in these cases was to help return the child

to the role of being a child in the family.

The Adult-Adolescent Parenting Inventory (AAPI) was chosen for inclusion in the present study because two of its scales measure the constructs of role reversal and empathy. The AAPI was developed by Bavolek (1984) to assess the parenting and child-rearing attitudes of adults and adolescents. In the AAPI, empathy is defined as the ability of the parents to "be aware of their children's needs, and to be able to respond to those needs in an appropriate fashion" (p.6). Role reversal is defined as a situation where the parent "acts like a helpless, needy child looking to his/her own child as if it were an adult who could provide parental care and comfort" (p. 7).

Each of the two scales of the AAPI is comprised of eight (8) items. Respondents are asked to rank statements on a five point scale ranging from "strongly agree" to "strongly disagree." On the empathy scale, statements focus on how parents understand and nurture children. The following are examples: (1) "Parents spoil their children by picking them up and comforting them when they cry"; and (2) "Young children who feel secure often grow up expecting too much." Responses to these statements are tallied and compared to norms on a continuum ranging from "lack of empathy" to "appropriate empathy."

In the role reversal scale, statements concern parents' expectations that the child should meet the parents' needs. The following are examples: (1) "Young children should be expected to comfort their mother when she is blue"; and (2) "A good child will comfort both of his/her parents after the parents have argued." Again, answers are placed on a continuum based on

normative data, ranging from "reverses family roles" to "appropriate family roles".

As Bavolek (1984) points out, in abusive families role reversal is often linked to a lack of empathy. However, the two behaviors are quite different:

> When abusive parents fail to show an empathic awareness for their children's needs, the children are often left to care for themselves. Carried to the extreme, children are physically and/or emotionally neglected or abused. The emphasis is not placed on children assuming the role of the 'nurturing parents' as in role reversal. In the latter situation, children are an integral part of the family functions, often becoming a source of authority, control, and decision-making (p.8)

Findings pertaining to empathy and role reversal:

The great majority of mothers in the sample did not evidence problems of empathy according to the AAPI; only 21% of the group fell in the below average range. This percentage of mothers who "lack nurturing skills" or "fear spoiling children" was slightly less than the distribution in a general population of non-abusive adults (31%). However, the percentage of mothers in the above average range (which includes such descriptors as "understands and values children's needs" and "recognizes feelings of children") was far less than the percentage in the general population of non-abusive adults (12% in our sample versus 31% in the general population).

More than half (54%) of the mothers in the sample scored in the below average range on the role reversal measure, as compared with 31% of the general population of non-abusive adults. Scores in the below average range indicate a tendency to "treat children as confidants or peers", "use children to meet self needs", or "perceive children as objects for adult gratification".

Role reversal was found to be related to mother's abuse history. Mothers with a history of sexual victimization in their own childhoods had more inappropriate role expectations than those mothers who did not report that they had been sexually abused as children ($F = 3.11$, $p < .01$).

5. THE RELATIONSHIP BETWEEN SOCIAL SUPPORT, MASTERY, PARENTAL EMPATHY AND ROLE REVERSAL IN MOTHERS

The previous sections have included discussion about the functioning of the mothers in the study as measured by the social support, mastery, empathy and role-reversal questionnaires, and how a mother's history of sexual victimization affects her scores on these measures. While the questionnaires give interesting information about different areas of functioning, do they have any relationship to each other? Do inappropriate expectations of children result in a higher reliance on children for social support? Does a sense of mastery and control over events in one's environment correlate with a more extensive social support network? In order to learn more about these relationships, correlations were done, and can be found in Table II. Findings from those correlations are described below:

> The kind of social support network mothers had was found to be related to Mastery, Empathy, and Role reversal. First, it was found that the number of friends and relatives in the social network was related to empathy; the more empathy toward children a mother had (i.e. score on Empathy scale), the more friends (r=.35) and relatives (r=.70) she was able to turn to for social support. Similarly, mothers with more internal mastery (the sense of being in control of life events) had a larger number of relatives upon whom they relied for support (r=.47), and more frequently turned to friends (r=.33) and relatives (r=.34) for emotional support.

Why should empathy towards children or sense of control over one's life have an impact on relationships with other adults? In regard to empathy, it may be that adults who are able to correctly perceive the needs of children are also able to perceive the needs of adults around them, and have more functional relationships with them.

It was found that mothers with higher empathy also had more positive expectations of the benefits of turning to others for social support (Network Orientation)(r=.46).

This may indirectly support the idea that empathy towards children and an openness toward relationships with others are related to increased support from relatives and friends.

The relationship between mastery and social support is less clear. From the above findings, however, it does seem that available social supports and a sense of control over one's life are related.

Could it be that the ability to turn often to friends and relatives increases one's sense of control over life events? Does life seem less out of control to mothers who have others to whom they can turn? Mastery, too, was found to be related to positive expectations of interactions with others.

Do mothers who have less appropriate expectations of their children tend to turn to their children more for social support than other mothers?

The findings suggest that mothers with more "role-reversal" looked to their children more often as sources of social support for affective (r=-.25), informational (r=.29), and instrumental (r=.29) social support than mothers with more appropriate role expectations. In this case, the same phenomenon (using one's children for social support) was picked up by two very different means of measurement. Interestingly, no relationship was found, however, between parental empathy and reliance on children for social support; mothers who reported turning to their children for social support were not found to be less empathic towards their children.

High role-reversal scores were also found to be related to the number of times a mother reported that she had no one to turn to for aspects of social support. The more inappropriate the role expectations, the more mothers reported that they had no one to turn to for various situations in which social support is often given (r=-.38).

Inappropriate role expectations, then, may have similar effects on one's adult relationships as discussed with regard to empathy, and are also related to low expectations of positive results of interactions with others.

> Mothers who experienced themselves as more able to control events in their lives also had more appropriate role expectations of their children than mothers who had more external mastery (r=.47). Thus the relationship between a sense of being in control, appropriate role expectations of children, and a more fruitful set of social connections with others seems clearer.

TABLE II

INTERRELATIONSHIPS BETWEEN MEASURES OF MOTHER'S FUNCTIONING
Significant correlations (r values) between measures

	EMPATHY	ROLE REVERSAL	MASTERY
SOCIAL SUPPORT:			
NETWORK ORIENTATION	.46 **	.42 *	.39 *
NUMBER OF PEOPLE			
Friend			
Socializing			
Affective	.40 +		
Informational			
Instrumental	.28 +		
AVERAGE	.35 *		
Relative			
Socializing			.61 ***
Affective	.47 *		.37 *
Informational	.49 *		
Instrumental			.36 *
AVERAGE	.70 **		.47 *
OCCASIONS OF USE			
Friend			
Socializing			
Affective	.34 +		.33 +
Informational			
Instrumental			
TOTAL			
Relative			
Socializing			
Affective			.34 +
Informational			
Instrumental			.39 *
TOTAL			.43 *
Children			
Socializing			
Affective		-.25 +	
Informational		-.29 +	
Instrumental		-.29 +	
TOTAL			
No one			
Socializing			
Affective			.33 +
Informational			
Instrumental			
TOTAL		-.38 *	

+ p < .10
* p < .05
** p < .01
*** p < .005

C. RELATIONSHIPS BETWEEN MOTHER AND CHILD FUNCTIONING

In previous sections we have observed that the nature of a child's background and the abuse characteristics affected scores on the measures of child functioning, and how aspects of behavioral symptoms, locus of control, and nurturance in children and adolescents were interrelated. We have also seen how a mother's history of sexual abuse affected a sense of control over her life and expectations of her children, as well as the existence of interesting interrelationships between mastery, empathy, role reversal, and social support. How, then, does the functioning of the mothers in areas such as mastery, social support, and role reversal and empathy affect the functioning of their children?

In fact, in a number of instances, an aspect of the mother's functioning was related to the child's functioning. The first of these was in the area of mastery, the sense of having control over events in one's life:

> Mothers who felt less in control of their lives had children (younger children: r=.54 and adolescents: r=.56) who also felt that events in their lives were out of their control, and were reported to be more anxious, somatic, and depressed (internalizing symptoms on the CBCL), than the children of mothers who felt more in control (younger children: r=.41 and adolescents: r=.50). In other words, when mothers feel that they are not in control, their children feel similarly, and tend to internalize their feelings. The adolescent children of these mothers are less likely to turn to them for nurturance and support (r=-.67) as if they perceive their mothers as less available to nurture them. This was not found to be true, however, for younger children.
>
> In contrast, positive aspects of mothers' functioning can also be seen in their children's functioning. Mothers who scored high on the empathy scale had adolescent children who turned to them more for nurturance and support (r=.51), felt more in control over events in their lives (r=-.67),

and had fewer internalizing (r=-.44) and externalizing behavior problems (r=-.59). It is not clear why these effects were not seen among the younger children of mothers with high empathy. It does seem that the more a mother can understand the point of view of her adolescent child, the more comfortable it is for the adolescent to turn to her for support, and the fewer symptoms are reported for the adolescent victim of sexual abuse.

The appropriateness of role expectations also increases the likelihood that an adolescent will turn to her mother for support. Adolescent children of mothers with more appropriate role expectations turn to their mothers more for support and nurturance than do adolescent children of mothers with more inappropriate expectations (r=.44). These adolescents also tend to have less externalizing or acting-out symptoms on the CBCL (r=-.57) This finding implies that inappropriate role expectations result in more symptomatology in victims, and less availability of maternal support.

What might be the effect of a mother's social support network on her children? Would a mother with good support from her friends have children that would be different than children of mothers with little support? Some important relationships between maternal social support and children's report of who they turn to for support (Nurturance) were found to exist.

It was found that the more mothers were able to turn to their own friends for social support, the more their younger (r=.71) and adolescent children (r=.52) reported that they turned to their mother for support and nurturance. Not only were children of mothers who were able to utilize their friends for support able to turn to their mothers, the adolescents also tended to turn more to their own friends for support (r=.52). These findings seem to imply that social isolation has a wider impact than on the adult alone. When mothers are supported in their own lives, they may be more able to provide support to their children. In contrast, the more mothers reported that they had no one to turn to for support, the more their adolescent children said they had no one to turn to (r=.84).

Lack of social support in the mother's life also seems to have impact on the availability of support in her adolescent

child's life.

Each of these findings have implications for case management and treatment. One would predict that helping mothers to increase their empathy for their children, and develop realistic role expectations may directly benefit the child victim of sexual abuse. Helping mothers feel more in control of events in their lives, and draw more on their own social supports, can be predicted to lead to less symptomatology in their children and greater ability of the children to turn to their mothers for nurturance and support.

TABLE III

RELATIONSHIPS BETWEEN CHILD SCORES AND MOTHER SCORES

Significant correlations (r values) between child scores and mother scores

	Mastery[1]	Role-Reversal[2]	Empathy[3]	Mother Social Support: Friend[4]	Mother Social Support: No One[4]
Child Scores:					
Behavior: (CBCL)[6]					
Internalizing:					
Young Child	.41 (*)				
Adolescent	.50 +		-.44 +		
Externalizing:					
Young Child		-.49 +			
Adolescent		-.57 +	-.59 *		
Locus of Control:[7]					
Young Child	.54 *				
Adolescent	.56 +		-.67 *		
Nurturance:					
Turning to Mother:[8]					
Young Child				.71 **	
Adolescent	-.67 *	.44 +	.51 +	.52 +	
Turning to Friend:[9]					
Young Child					
Adolescent			.52 +		
Turning to No One[10]					
Young Child					
Adolescent			-.61 *	.84 ***	

+ p < .10
* p < .05
** p < .01
*** p < .005

1 Higher raw scores reflect more external mastery
2 Higher raw scores reflect more appropriate role expectations
3 Higher raw scores reflect more empathy toward child(ren)
4 Higher raw scores reflect more turning to friends
5 Higher raw scores reflect more turning to noone
6 Higher raw scores reflect more symptomatology
7 Higher raw scores reflect more external locus of control
8 Higher raw scores reflect more turning to mother
9 Higher raw scores reflect more turning to friends
10 Higher raw scores reflect more turning to noone

CHAPTER III: PSYCHOTHERAPY CONTENT, INTERVENTION, AND GOALS

The following chapter analyzes the content of the therapy carried out with the children and their mothers. It is based on interviews with the therapists and looks at the topics (subject of discussion), activities (specific interventions employed by the therapist) and intentions (therapist's rationale for making a particular intervention) in the therapy. The frequency of all topics, activities and intentions were compared by: individual vs. group therapy; treatment with younger children vs. adolescents; relationship to offender; duration of the abuse; penetration vs. non-penetration; phases of therapy; and scores on the pretest measures. A summary of these findings as they pertain to the therapy with children is presented first followed by a summary of the therapy with mothers.

A. THERAPY WITH CHILD VICTIMS

1. THE CONTENT OF THERAPY

Sexual abuse is a frequent topic in the therapy of child victims. Overall, issues pertaining to the nature and impact of current or past abuse (for any family member), details of interactions with the offender, and dilemmas concerning criminal justice system involvement (adjudication of the offender, court proceedings, etc.) comprised nearly a third (32%) of all the topics that were discussed during the critical moments of therapy with children.

Sexual abuse is talked about much more frequently in group therapy than in individual therapy. In group therapy, sexual

abuse constituted nearly half (41%) of all the topics that were discussed during the critical moments of therapy. Often, the subject was initiated as part of a planned exercise by the group leader; in one group for adolescent victims, for example, the therapist asked the members to develop a list of questions they had about the offenders' motivations in abusing them. Those questions were then raised in an actual meeting with the offenders. In another group, members were asked to discuss how they would like to see the offenders punished.

The critical events of individual psychotherapy were more likely to be organized around the topic of sexual abuse when the child victim was having ongoing contact with the offender ($p<.10$). Sometimes this contact became the basis for discussion of prior abuse dynamics. For example, a therapist used a child's talk about shopping trips with her father (during which she would "model" clothes) to note how her father had always been seductive with her.

The topic of sexual abuse was also more likely to be a component of the critical moments of therapy when the abuse was more recent ($p<.01$). In other words, the more time that passed between the last known incident of abuse and the start of treatment, the more the critical content of therapy seemed to center on other matters, such as school, peer relations, or family.

As might be expected, therapists and children discussed sexual abuse less often as individual therapy progressed. Sexual abuse constituted about 40% of all topics that were deemed important by therapists during the "beginning phase" of therapy

(i.e., the first twelve sessions), but only 15% of all topics during the "final phase" of therapy (i.e., beyond the twenty-fourth session). In this later stage discussion of peer, family and school issues increased threefold ($p<.01$).

In individual treatment, sexual abuse appeared much more frequently as a topic in the therapy of younger children and particularly with younger children who were more anxious, withdrawn or depressed ($p<.05$). Often the topic was approached and discussed indirectly, as in the case of a six year old girl who had been forced to perform oral sex on her mother's live-in boyfriend, and who was described by her mother on the CBCL, as someone who was "fearful," "secretive," and "self conscious or easily embarrassed." Here, the therapist used various play therapy materials (anatomically correct dolls, drawings, etc.) over the course of therapy to gradually learn more about the child's "secrets" (which included physical as well as sexual abuse) and fears (she thought she would go to jail for what she had done), and to help her express her anger about the abuse (a punching bag was often the target).

With adolescents, sexual abuse was the topic of critical moments of therapy more often with those who felt less control over events in their lives ($p<.05$). For example, a fifteen year old, abused by her step-father, indicated on the Children's Locus of Control Scale that she believed that when "bad things" happened to her it was "usually her own fault", and that children her age could "never have their own way". During therapy the therapist and she talked about all the ways she was "forced to grow up too early," and the therapist later used the "empty

chair" technique ("If your step-father was sitting there right now what would you say to him?") to help her become more assertive.

Issues pertaining to the therapist and the therapy were the second most frequent topics in the therapy of child victims. About one of every five critical topics (22%) involved: either the child's perceptions of or relationship with the therapist; whether termination was indicated; or some practical consideration relating to the conduct of therapy (schedules, ground rules, frequency of sessions, use of other modalities). As might be expected, therapists were more likely to initiate such topics ($p<.005$).

Family issues, involving such subjects as communication and conflict between family members, the behavior of individuals in the family, and family rules and methods of handling problems, were the topics in approximately one of every seven events (14%) viewed as critical in the therapy of adolescents and young children. Adolescents talked with therapists about family matters more frequently than younger children. Often, these matters concerned mother-daughter conflicts (discipline, lack of trust etc.). Where these impasses appeared to be related to the sexual abuse, the therapists often worked to help the child understand how unresolved feelings might heighten the conflict. For example, a sixteen year old took an overdose of sleeping pills after being grounded by her mother for poor grades. The therapist responded by exploring the girl's reactions to her father's recent indictment on criminal charges (she felt guilty and depressed), thereby suggesting other reasons for their disputes and the

girl's suicidal behavior. In another case, the therapist responded to the child's description of clashes with her mother by saying: "You cut each other up, but you're both really angry at other people, and you're both really hurt".

Discussion of family issues occurred more frequently with young children who did not often cite their mothers to be sources of support and nurturance on the Nurturance Scale ($p<.005$). A ten year old girl, for example, who did not identify her mother during pretesting as someone she would turn to with "problems or worries," tell "important things to," or want to be with if she (child) was "upset or unhappy," told her therapist during one meeting that her mother was often not around to talk to her. The therapist, who did not want the girl to blame herself for this, replied: "Your mother has a lot of problems of her own, and has a hard time listening to you. Maybe you'll have to get your needs to talk met in another way."

About one of every ten critical events (11%) centered on the child victim's thoughts and feelings about him or herself. Adolescents and younger children alike talked with their therapists about their worries, fears, and fantasies. Often, these experiences involved issues of self image and body integrity, as in the case of the adolescent who spoke about her frequent need to take showers, because she felt so "dirty." With young children, therapy topics were more likely to consist of these self-experiences when the child was someone who exhibited internalized symptoms and problems ($p<.05$). Frequently, young children who were anxious or withdrawn, generalized their worries and concerns. One child, for example, despaired that his mother

would die; another was tormented by thoughts that children in the neighborhood would die.

About one of every ten critical topics (11%) concerned the child victim's interactions with friends and peers, or functioning in school (the topic category called "living in the world"). Most often, these issues were initiated by the child or adolescent rather than the therapist ($p<.05$), and they were more likely to surface during the later stages of therapy. Finally, these issues were more likely to arise as topics in the therapy of young children and adolescents for whom there had been a considerable time lapse between the last known incident of sexual abuse and the start of therapy ($p<.10$).

Although protective issues arose at least once in more than half of the cases in the study (11 of 21), these issues were not frequent topics in the therapy sessions that were sampled. Matters affecting the safety of family members (e.g., parental competencies, drug and alcohol abuse), issues concerning violations of boundaries between family members (e.g., living arrangements, privacy, inappropriate role expectations), and items involving system response to the abuse (e.g., investigation, placement) comprised only 7% of the all the topics that were reported in the therapy of child victims. Protective topics were more likely to be discussed within the confines of individual rather than group therapy, and more likely to be discussed with young children who exhibited more "acting out" symptomatology as reported on the CBCL ($p<.05$). One therapist, for example, talked with a sexually aggressive young girl about sleeping arrangements in her house after observing the girl

placing all the family member/dolls in the same bed during a play therapy session. It should be noted that, when protective issues did arise in therapy, therapists often worked to achieve what one called "that delicate balance between treatment and investigation." Interestingly, although the therapy of both younger and older children sometimes included the protective issues of "parentification" (e.g., excessive household responsibilities, taking care of extended family members), no relationship was found between the occurrence of protective topics and the extent to which child victims perceived their mothers to be available for nurturance and support.

Table IV compares the topics of group and individual treatment, and Table V presents the topics of therapy of younger and adolescent victims.

TABLE IV

TOPICS OF CRITICAL INCIDENTS:
INDIVIDUAL VS. GROUP TREATMENT OF CHILDREN

Topics:	Individual %	Group %
Sexual Abuse	28%	41%
Therapy and Therapist	20%	27%
Family Issues	16%	11%
Living in the World	13%	7%
Experience of the Self	12%	10%
Protective/ Boundaries	8%	4%
Silence, play	3%	0%

$F=19.03$, $p<.005$

TABLE V

TOPICS OF CRITICAL INCIDENTS:
INDIVIDUAL TREATMENT OF YOUNGER CHILDREN VS. ADOLESCENTS

Topics:	Age 6-11	Age 12-16	
Sexual Abuse	34	16	***
Therapy and Therapist	26	19	
Family Issues	13	24	*
Living in the World	10	15	
Experience of the Self	9	13	
Protective/ Boundaries	5	10	
Silence, play	3	4	

* = $p < .10$ *** = $p < .01$

2. INTERVENTIONS IN THERAPY

Of the techniques that were judged by therapists to be important in the treatment of child victims, the one employed most frequently was an inquiry into the child's thoughts and feelings, and perceptions of people and events. This request for elaboration serves not only to elicit information but also to direct the child's attention to selected aspects of the problem at hand. For example, in asking an adolescent, "What do you think having a baby would be like?" the therapist not only learns something about the adolescent's fantasies (or coping skills), but also brings potential problems of child-rearing to the client's consciousness. Inquiries of this kind comprised one quarter (25%) of all therapist activities during the critical moments of therapy. The therapist often explored the child's reactions to, and feelings about, the abuse and its aftermath. Sometimes these explorations served to link past experiences and current feelings. For example, when an adolescent victim told her therapist that her father "always acted like more of a

boyfriend" to her, the therapist asked her what effect she thought that had on her current feelings toward boys (she didn't like them coming near her).

In group therapy, therapists' requests for their clients' perceptions might be directed at a single member, or the group as a whole. Therapists often asked members to comment on various aspects of group process and structure, frequently as an attempt to empower them and promote a sense of group cohesion. In one group, the therapist asked the group to determine how individual members could share personal concerns without monopolizing the group. In another group, members were asked to decide how a subsequent meeting with a group of offenders should be handled. In other instances, the request to the group was made simply so that a topic could be amplified, as in the case of a group of adolescent victims who were asked to talk about the different ways they mask their feelings about the abuse.

In their work with sexually abused children, therapists employ supportive and directive techniques in about equal measure (18% versus 15%). Therapists offer advice, suggest options, or attempt to structure the therapy (by assigning tasks, modeling behaviors, using role plays, etc.) with child victims almost as often as they try to convey empathy, sympathy, or reassurance, or use praise or encouragement to reinforce certain feelings and behaviors.

Therapists did intervene in different ways, however, according to the mode of therapy that they employed. They were, for example, much more directive in group therapy and much more supportive in individual therapy with victims. More than one

quarter (28%) of all the group work interventions that therapists deemed important involved directed or structured activities. Most often, therapists used such methods in groups to build and maintain relationships between members (members might be asked to write out a list of their likes and dislikes, for example). Structured exercises were also often used in group to help children anticipate problematic situations and develop new coping skills. In one group the therapist had members play roles in a vignette involving a teen-age boy who makes advances toward a girl during their first date; the girl said she was uncomfortable, and the members were asked to demonstrate how they would handle the situation. In another group the leader presided over a "mock trial," in order to "demystify" the court process for those who would be called upon to testify.

Therapists were also more likely to be directive with young children who had higher externalizing scores on the CBCL, e.g., acting out behaviors ($p<.05$). Here the interventions might have taken the form of suggestions about alternative ways of responding to those problems.

The victim's (young children and adolescents) relationship with the offender was a determinant of the extent to which supportive interventions comprised the critical moments of individual therapy. Therapists were more apt to convey support or offer encouragement when the victim was assaulted by a father or father figure, than when the offender was an extended or non-family member ($p<.05$). Quite possibly, therapists recognize that the trauma of sexual abuse by a father or father figure tends to be more severe given the betrayal of trust and loyalty conflicts.

In individual treatment, therapists used supportive techniques most often when young children or adolescents talked about relationships with people outside the family (i.e., friends, boyfriends) or events in school. They were also more supportive to victims who identified fewer instances in which s/he could turn to friends on the Nurturance Scale (younger children: $p<.005$; adolescents: $p<.05$). Therapists often tried to praise the children's attempts to make new friends or sympathize with their feelings about the lack of friends. (E.g., "It's really hard when you want to hear from someone and they don't call.") Similarly, with regard to school, therapists commended "hard work," and empathically recognized barriers to achievement. (E.g.,"It's difficult to concentrate when you're thinking of so many other things.") It should here be noted that the support offered by therapists to both young children and adolescents wasn't always verbal. Sometimes (5% of all critical activities) therapists simply sat in silence, listened, and tried to "be with" the child as he or she talked.

The therapeutic technique of providing information to the younger children and adolescents clients was used in 12% of all critical incidents. Sometimes therapists gave normative information to help victims see that they were not alone in their feelings. Among the critical interventions that therapists reported were such statements as: "Kids who've been sexually abused usually feel that they're to blame for everything:" and "Kids often feel scared when they have to go to court." Therapists also gave factual data to victims in order to correct cognitive distortions. In one group, for example, during a

discussion concerning offenders, the therapist said, "It's important to know that although offenders are sick and need help, they usually deny that they have any problems. Instead, they try to get others to feel bad for them." Therapists used more "informing" techniques with acting out adolescent victims ($p<.01$).

Somewhat less frequently than they offered information to young children and adolescents, therapists commented on the victim's thoughts, feelings, and behaviors (10%). Therapists commented most often in response to the topics involving family issues, and they were far more likely to comment on these issues within the context of individual therapy. Among the "commenting" techniques were such interventions as:

A) Reflecting: restating or rephrasing the child's statements ("Sounds like you're pretty mad at her").
B) Confronting: Pointing out that a child's thoughts or actions are contradictory or conflicting ("Do you really think that what happened had no effect on you?").
C) Reframing: Suggesting an alternative way of viewing a situation ("Maybe your mother called not to harass you, but because she missed you").
D) Changing/Maintaining Focus: Attempting to focus or refocus the discussion ("Let's get back to what you said before about the kids teasing you").

In their work with sexually abused children, therapists did not often employ the traditional psychotherapeutic method of interpreting, or "making connections" between unconscious and conscious acts and motives. In all, the "making connections" category comprised 8% of all the critical activities of therapy. Three cases are illustrative: in the first case, a nine year old girl cried while talking about a teacher who liked her. The

therapist, who wanted the child to see that she was depressed about the lack of warmth and caring in her family, suggested "It makes you feel sad when someone cares about you." In the second case, a young child was acting out (hitting other children) while waiting for her meeting with the therapist. When they did meet, the therapist immediately said "It seems like its hard for you to wait. When things worry you or you're bothered, it makes you get into trouble." Here, the attempt was to connect feelings to behavior. In the third instance, a teen-ager worried out loud that her mother "won't be able to handle all this (the aftermath of the abuse)-- she'll fall apart." The therapist then expressed her opinion that this might be why the girl so often felt the need to be "perfect." The therapists aim in making this interpretation was "to help her see that she puts pressure on herself never to fail so that her mother can rely on her strength."

Therapists were more likely to use interpretive interventions with children who had been abused by fathers or father figures than with those who had been abused by extended or non-family members ($p<.10$). Perhaps more interpretive interventions were used to help the child sort through the emotional turmoil of being hurt by someone they love and are involved with on a daily basis. Therapists interpreted the thoughts, feelings and behaviors of adolescent victims more often (11%) than younger victims (5%).

Only rarely did a critical activity in therapy involve a request for factual information from the child. Such requests constituted only 8% of all important interventions. As might be

expected, these requests were usually attempts to learn more information about the nature of past or suspected abuse, to assess other protective issues, or to gather personal, developmental or family data.

A comparison of therapeutic interventions between individual and group therapy can be found in Table VI. Therapeutic interventions in the treatment of younger vs. adolescent children are presented in Table VII.

Table VI

ACTIVITIES OF CRITICAL INCIDENTS:
INDIVIDUAL VS. GROUP TREATMENT OF CHILDREN

Activities:	Individual %	Group %
Asking Client's Perception	23%	29%
Directing	15%	28%
Reinforcement/Supportive	19%	10%
Informing	12%	8%
Commentary	12%	4%
Making Connections	7%	10%
Information Seeking	7%	4%
Listening, Silence	4%	7%

F=25.2, p < .001

TABLE VII

ACTIVITIES OF CRITICAL INCIDENTS:
INDIVIDUAL TREATMENT OF YOUNGER CHILDREN VS. ADOLESCENTS

Activities:	Ages 6-11 %	Ages 12-16 %	
Asking Client's Perception	25	22	
Directing	16	11	
Reinforcement/Supportive	16	21	
Informing	15	10	
Commentary	10	16	
Making Connections	5	11	*
Information Seeking	10	4	**
Listening, Silence	3	5	

* = p <.10 ** = p <.05

3. GOALS AND INTENTIONS IN THERAPY

In working with sexually abused children, the therapist's choice of treatment techniques is often guided simply by his or her need to understand the child's situation at a particular point in time. When the clinicians in the study were asked their rationale for using a certain intervention in therapy, they most often said that they had done so to enhance their own understanding of the case. Of the treatment goals that were identified by therapists, about one of every five (19%) involved an appraisal of the child's reactions, ideas, thoughts, feelings, and/or life circumstances. Such assessment constituted a much greater proportion of therapeutic aims in individual therapy than in group therapy (23% versus 7%), and in the individual therapy of young (as opposed to adolescent) victims (27% vs. 16%). Therapists also reported a more frequent need to understand the situations and life circumstances of young children whose mothers were not as available for nurturance and support.

The next most frequently mentioned treatment goal was that of support. Therapists often intervened with the goal of communicating to children that their feelings and experiences were valid, and were understood. About one of every six of the important goals of therapy (17%) involved this supportive function. Therapists intervened for supportive purposes more often in cases where the child was abused by a father or father figure ($p<.05$) and had ongoing contact with the offender ($p<.05$).

Maintaining or improving the therapeutic relationship (helping the child feel more comfortable in therapy, planning for termination or transfer, etc.) was the objective in 15% of the

critical moments of therapy. Group leaders were more likely to ascribe to these objectives than were individual therapists.

Although the clinicians in the study did not often interpret unconscious material in their work with sexually abused children, their interventions were at times immediately aimed at increasing self understanding, i.e., at helping the child better understand thoughts, feelings, and events. "Insight" goals comprised 14% of the intentions reported. Insight was a more frequent objective in the treatment of adolescents than of young children.

Another treatment objective with children was improving individual and family functioning. Among the aims contained in this category were reducing family conflicts, developing healthy defenses, and increasing the child's coping and communication skills. Together, these aims comprised 11% of the reported intentions.

Somewhat less frequently, therapists intervened in order to simply help children express their feelings, to educate or to empower children. Expressive objectives (catharsis), educative aims (improving the child's understanding of the motivations and behaviors of others, instructing on practical matters, etc.), and empowerment goals (helping child victims -- significantly adolescents -- gain a sense that they can overcome problems), comprised 9%, 8%, and 7% of all reported intentions, respectively.

The distribution of intentions in individual and group therapy can be found in Table VIII. A comparison of the goals of treatment of younger and adolescent children appears in Table IX.

TABLE VIII

INTENTIONS OF CRITICAL INCIDENTS:
INDIVIDUAL VS. GROUP TREATMENT OF CHILDREN

	Individual %	Group %
Enhance Understanding/ Assessment	23%	7%
Support	18%	14%
Therapeutic Alliance	12%	22%
Insight	12%	19%
Improving Functioning	12%	7%
Catharsis	8%	10%
Education	7%	10%
Empowerment/Mastery	6%	10%

F=29.99, p<.001

TABLE IX

INTENTIONS OF CRITICAL INCIDENTS:
INDIVIDUAL THERAPY OF YOUNGER CHILDREN VS. ADOLESCENTS

Intentions:	Ages 6-11 %	Ages 12-16 %	
Enhance Understanding/ Assessment	27	16	**
Support	20	17	
Insight	7	17	**
Therapeutic Alliance	15	12	
Improving Functioning	12	13	
Catharsis	10	5	
Education	6	9	
Empowerment/Mastery	3	10	**

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* = p <.10 ** = p <.05 *** = p <.01

B. THERAPY WITH MOTHERS OF SEXUALLY ABUSED CHILDREN

As might be expected, the topics of therapy with mothers were quite different from those of therapy with children. For example, whereas sexual abuse was the topic most often reported in the therapy of children, family issues (which constituted 27% of all topics) were talked about most frequently in treatment of mothers. More often than not, mothers initiated family topics.

Protective issues (safety, boundaries, role expectations, etc.) were topics discussed more often in the therapy of mothers than they were with children, and relationships outside the family were discussed less often in the therapy of mothers (except for mothers who had more extensive social support networks, particularly friends ($p<.05$). When child protective matters were talked about, most often it was with those who found it more difficult to assume the perspective of their children (i.e., who evidenced problems with empathy).

As was true in the therapy of child victims, topics that concerned the mother's own thoughts and feelings about herself constituted about one of every ten (12%) of the critical topics of therapy. Topics of this kind appeared more frequently in the therapy of mothers who felt less in control over events in their lives ($p<.05$) and in the therapy of those who had more inappropriate role expectations of their children (role reversal) ($p<.01$).

In terms of interventions, therapists used structured activities and other directive interventions far less often with mothers than with children. When therapists did offer advice to mothers, their recommendations often took the form of alternative

methods for handling "intrusiveness" (i.e., child behavior problems, demands made by relatives and partners, etc.). Occasionally, the suggestions involved ways of coping with abuse-related issues and problems, as in the case of the therapist who advised a mother on ways to create "quiet time" with her daughter a few days prior to the child's scheduled testimony before a Grand Jury. Overall, therapists tended to be more directive with less empathic mothers ($p<.005$).

As might be expected, therapists were more likely to comment on the topics initiated by mothers than on those initiated by children. As with children, though, therapists used confrontation and reflection to help mothers better understand relationships with others. To a mother who downplayed problems with her boyfriend's drinking and violent behavior, for example, one therapist commented, "It sounds to me like you're minimizing the problem. Maybe that's just a way of justifying staying with him."

As in the treatment of children, therapists did not often interpret mothers' thoughts, feelings, and behaviors ("making connections" comprised only 9% of all critical interventions).

The goals of therapy for mothers were remarkably similar to the aims of therapy with children. The largest proportion of the interventions made in the therapy of both mothers and children were done with the goal of assessment or enhancing the therapist's understanding of the case. This assessment function comprised even a larger portion of the therapy of mothers than with children. Goals concerning the therapeutic relationship (making the client feel more comfortable in therapy, planning for termination, etc.) were less prevalent in the therapy of mothers.

All other therapeutic intentions (support, insight, improving functioning, catharsis, education and empowerment) were cited in very similar proportions by therapists of mothers and children. As with children, the goal of empowerment and mastery was surprisingly infrequent.

Table X compares the topics, activities and intentions of the individual therapy of children with those of the therapy of mothers.

TABLE X

CRITICAL INCIDENTS:
INDIVIDUAL TREATMENT OF CHILDREN VS. MOTHERS

Topics:	Children	Mothers
Sexual Abuse	28%	24%
Therapy and Therapist	20%	20%
Family Issues	16%	27%
Living in the World	13%	6%
Experience of the Self	12%	12%
Protective/ Boundaries	8%	12%
Silence, play	3%	0%
F=23.7, p < .001		
Activities:		
Asking Client's Perception	23%	19%
Directing	15%	8%
Reinforcement/Supportive	19%	13%
Informing	12%	13%
Commentary	12%	20%
Making Connections	7%	9%
Information Seeking	7%	9%
Listening, Silence	4%	9%
F=19.5, p < .01		
Intentions:		
Enhance Understanding/ Assessment	23%	30%
Support	18%	16%
Insight	12%	13%
Therapeutic Alliance	12%	5%
Improving Functioning	12%	16%
Catharsis	8%	4%
Education	8%	9%
Empowerment/Mastery	6%	7%
F=18.0, p < .01		

CHAPTER IV: FUNCTIONING OF SEXUALLY ABUSED CHILDREN AND THEIR MOTHERS AT POST-TESTING

As detailed in Chapter I, the children and mothers who participated in the study were administered a set of questionnaires as they entered the study and as they left. This chapter looks at measurable treatment outcomes as demonstrated by comparisons of subjects' scores at the beginning of treatment and after eight or more months in therapy.

A. SEXUALLY ABUSED CHILDREN

It was not possible to administer the post-tests to all of the children who participated in the study. Twenty-two children completed post-testing. In two families, the victim's mother refused to allow the victim to return to take the questionnaires. Three children could not be located to arrange for post-testing.

While the design of the study called for post-testing after one year, most of the children were administered the post-tests before one year had passed. Thirteen children terminated treatment before the one year mark. Seven of these experienced what their therapist deemed was an appropriate termination. An average of 44 weeks had elapsed from pre-test to post-test. Six children terminated treatment at an "inappropriate" time, after an average of 38 weeks since pre-testing. In the cases of six other children, the study period ended before they completed one year's treatment, with an average of 41 weeks elapsed since pre-testing, (and these children remained in treatment after post-testing). Three children were post-tested after one year from

pre-testing, and also remained in therapy after post-testing.

1. BEHAVIORAL SYMPTOMS

(a) Child Behavior Checklist

The Child Behavior Checklist (CBCL) was filled out by 18 mothers (or guardians) at pre-test and post-test. A significant ($p<.01$) decrease in total behavior problems occurred over the course of the study period. Many of the children and adolescents, however, remained in the clinical range on this scale (83% were in the clinical range at pre-test; 61% were in the clinical range at post-test). Both the internalizing and externalizing scores decreased for the group. At pre-test, 72% of the children and adolescents were in the clinical range on the internalizing scale; at post-test, 56% remained in the clinical range. On the externalizing scale, 61% of the children and adolescents were in the clinical range at pre-test; 44% at post-test.

Children and adolescents who received only individual therapy were compared with those who received group and individual therapy and no statistically significant difference was found. However, the small number of children and adolescents still in the study at post-testing, and the large number of treatment and background variables which could have affected outcome make it difficult to draw any firm conclusions about the relative effectiveness of treatment modality, or to determine which other variables were related to improvement on the CBCL.

(b) The Sexual Abuse Symptom Checklist

The Sexual Abuse Symptom Checklist (SASC) was filled out for 24 children and adolescents by the therapists assigned to the case at pre-test and post-test. A significant ($p<.07$) reduction in behavioral symptoms occurred during the study period. The items which showed the greatest decrease (over 20%) are as follows:

- Isolated, feels different from others
- Feels transparent or stigmatized
- Feels guilty that offender is/may be incarcerated
- Clings to siblings
- Parentified
- Frightened by own sexual feeling or impulses

Although there was an overall decrease in the above symptoms, two items showed an increase (of at least 20%) at post-test. These items were:

- Fights with mother
- Fights with therapist

One possible explanation is that as the anger about the sexual abuse emerges, children and adolescents begin to express that anger directly at their mothers for their lack of protection. Further, the victim's anger about the abuse by a trusted adult may contribute to intense feelings of anger at the therapist as representative of an authority figure who had been so hurtful to them in the past. Kroth (1979) notes that it is not uncommon for victims towards the end of therapy to exhibit a decrease in anger at their incestuous fathers while showing no reduction in anger at their mothers. Haugaard and Reppucci (1988) elaborate on this theme by suggesting that "young children

may still view their parents as omnipotent and consequently, are likely to believe that their mothers knew about the abuse even when it was clear from other evidence that she did not know." This dynamic may also be operative for adolescents who are in the process of resolving issues around their abuse.

It is also striking to note the post-test scores indicate a reduction in the "parentified" role concomitant with an increase in fighting with mother. These findings may indicate a trend towards changes in the mother-child relationship. Perhaps, through the course of therapy, the victims were more able to express their anger at their mothers for having to function in a parental capacity, resulting in increased conflict between them.

Again, due to the small number of children and adolescents in the study at post-test, it was not possible to determine which variables had the greatest impact on these symptoms. It appears that the modality of treatment (individual vs. group) did not have a significant effect on outcome on the SASC. It could be concluded, however, that there was an overall reduction of sexual abuse specific behavioral symptoms in the group as a whole.

2. LOCUS OF CONTROL

Twenty-one children were administered the Bialer Locus of Control Scale at post-testing. There was no change in the mean scores for the group of young children and adolescents from pre-test ($\bar{x}$ = 25.7) to post-test ($\bar{x}$ = 25.4) on this measure of internal and external locus of control (Bialer 1961). Most of the scores were quite consistent from pre-test to post-test. While three children scored significantly higher internal scores,

another three had significantly higher external scores.

Another indicator of lack of change in a child's sense of feeling in control was provided by the Sexual Abuse Symptom Checklist. On the items which were related to mastery and control, the therapist's ratings by and large remained unchanged from pre-test to post-test.

Since an increased sense of mastery and control had been identified by surveyed therapists (Deveney et al., 1986) as a goal in the treatment of sexually abused children, why was no change found in this group of children who had been in treatment for about a year?

Locus of control has been found to be a construct which can be changed by psychotherapy. One study which showed such change (Omizo & Omizo, 1987) found a higher internal locus of control after seven weeks of group therapy (this was not a sexual abuse study, and it used a different locus of control measure).

One possible explanation for the lack of change in locus of control among the children and adolescents is that the issues of abuse were for many quite active throughout the study period, and far from having been resolved. For example, eight had some form of ongoing contact with the offender, and nine went to court (and in a number of cases, the offender was found to be innocent). Additional evidence of the presence of active abuse issues is provided by the ongoing protective monitoring by case managers (see the case management report), and the number of times interaction with the offender was the topic of therapy. In other words, it may be that much in the lives of these children remained out of their control.

Another possible reason for the consistency of locus of control scores is that issues other than mastery were addressed in the therapy of these children. The intention of "Empowerment" was cited in only 8% of all critical moments of therapy.

It is also possible that the instrument that was used in this study to measure locus of control was not sensitive to the kinds of changes seen in the psychotherapy of children who have been sexually abused.

3. NURTURANCE AND SUPPORT

The Child's Nurturance Scale (Saunders, 1979) was used in this study to determine whether the children and adolescents perceived that their mothers and friends were available to them for social support. It was also used to determine if there were conditions under which the victims felt that they had no one to turn to for support and nurturance. The Nurturance Scale was completed by twenty-one children at post-testing. No difference was found between pre-test ($\bar{x}$ = 5.2) and post-test ($\bar{x}$ = 5.1) in the number of times the victims said that would turn to their mothers for nurturance and support. This result may seem surprising, as one of the stated goals of the treatment of sexually abused children (Deveney, 1986) as stated by experienced therapists is increasing the availability of mothers to support their children.

One hypothesis for this finding is that the victims had not yet resolved their issues with their mothers about the abuse, and resolution was still in process. In support of this hypothesis, it is notable that on the Sexual Abuse Symptom Checklist, one of

the few symptoms which increased (almost all symptoms showed a decrease) was the item which stated, "Fights with mother". On the pre-test, this item was endorsed for 62% of the victims; at post-test, for 83% of the victims. Thus it may be that conflict with mothers increases during the first year of treatment, and the results of treatment are not immediately seen.

Reliance on friends for nurturance and support also stayed much the same (pre-test $\bar{x}$= 3.6, post-test $\bar{x}$= 3.8). The stability of the Nurturance Scale scores seems to indicate that no changes were noted through the use of the scale. An interesting, but not statistically significant change, however, was detected by the Nurturance Scale. Where 12 victims at pre-test reported that they had no one to turn to for nurturance in at least one situation posed by the Nurturance questionnaire, at post-testing, seven of these no longer had a "no one" response on the scale. In other words, there appeared to be overall increase in the amount of support available to the victims who previously had identified occasions when they had no one to turn to for support. The additional support appeared to come from a variety of sources.

B. MOTHERS OF SEXUALLY ABUSED CHILDREN

Post-tests were administered to nineteen mothers. Five mothers did not cooperate with efforts to arrange for post-testing.

Eleven mothers who were in treatment were post-tested after an average of 48 weeks from pre-testing. Only one terminated prematurely, three had appropriate terminations before the one

year study ended, and four were pretested after an average of 48 weeks because the study was drawing to a close. Eight of the mothers who were followed in the study were not in treatment themselves, but had children in therapy.

1. SOCIAL SUPPORT

The various scores derived from the Social Network Questionnaire remained constant from pre-test to post-test: there was no change. This proved true for the Network Orientation Scale as well. Change on these measures was expected, as experienced therapists stated as their goals to reduce the social isolation of the mothers of children who have been sexually abused.

A number of possibilities might account for the lack of change in social support. First, it may be that this group of mothers was not socially isolated. The lack of a control group in this study made it impossible to determine if this group of mothers of sexually abused children had more or less social support than mothers of children who had not been abused. In contrast, the two items on the Adult Symptom Checklist relevant to social support seem to indicate that the therapists perceived these mothers as lacking in support. Therapists endorsed the following items in 83% of the mothers at pre-test and 90% at post-test.

- Inadequate emotional support from family when dealing with difficult problems
- Inadequate emotional support from friends when dealing with difficult problems

Thus, by therapist report, the mothers had inadequate social

support from friends and relatives, which remained unchanged over the period of treatment. To help understand this issue, it would be worthwhile in the future to facilitate a comparison between this population and other populations.

A second possible explanation for the lack of change in social support is that the psychotherapy received by the mothers did not have an impact on their social support networks, and their ability to turn to others when they needed support. The psychotherapy critical event data seem to indicate that the stated goal of increasing social network support came up relatively infrequently - in only about 2% of the critical events.

2. MASTERY

There was no significant change between pre-test and post-test scores on the Pearlin Mastery Scale, although change was expected. A few hypotheses present themselves. First, it may be that the mothers in this study did not have a problem with mastery. The mean in our sample was lower (more internal mastery) than the mean or the distribution in three out of four other samples (Belle, 1979; Walford-Kraemer, 1984). Walford-Kraemer's college educated sample was the only sample with more internal mastery than the sample of mothers in the present study.

Nevertheless, it appears that the therapists who participated in this study found external mastery to be a problem among the mothers studied. On the Adult Symptom Checklist, the following mastery-related items were endorsed, with percentages

of mothers endorsed at pre-test included:

- Feels helpless in dealing with life's problems: 89%
- Unable to function autonomously: 78%
- Unable to assert herself in most situations: 67%

The above items also showed no significant change at post-test.

Another hypothesis for lack of change assumes that external mastery was a continuing problem among the mothers. As in the case of the children, the period following disclosure of sexual abuse is a time when much remains out of the control of a mother: the Department of Social Services is involved in her life, and in many cases court action is pending. So events were perceived as relatively out of control throughout the period examined, and so reported on the Mastery Scale.

A third hypothesis is that mastery was not something changed by the psychotherapy received by this group of mothers. The intention of "Empowerment," a close construct to mastery, was present in only 10% of the critical events in the therapy of the mothers.

3. PARENTING: EMPATHY AND ROLE REVERSAL

(a) Empathy

According to the norms published with the Adult Adolescent Parenting Inventory (AAPI), lack of empathy was not a problem in the study population of mothers: problems with empathy occurred about as often as they do in the general population. This did not change at post-test.

(b) Role Reversal

A significant ($p<.08$) improvement took place in the role reversal scores of the mothers in the present study. At pre-test, over half of the mothers were in the below-average range on the AAPI, which indicated that there was more role-reversal than in the general population. At post-test, only 32% of the mothers were in the below-average range on the AAPI, and the mothers more closely resembled the general population with regards to role-reversal.

While a definite link cannot be established, improving parenting skills was often the intention expressed by therapists in the critical event data. It is possible that this therapeutic work was related to improvement in the mothers' role-reversal. It is curious to note, however, that of the two items on the Adult Symptom Checklist which were related to role-reversal, one showed improvement from pre-test to post-test, while the other did not. The item "Age inappropriate expectations for child for household tasks and responsibilities" went from 67% at pre-test to 44% at post-test. The item, "Age inappropriate expectations for child to emotionally support parent" was 61% at both pre-test and post-test.

CHAPTER FIVE: SUMMARY AND RECOMMENDATIONS

A. FUNCTIONING AT PRE-TEST

Although the adverse effects of child sexual abuse may not appear immediately, a substantial body of clinical data points to the negative and often persistent impact of this kind of abuse (see DiPietro, 1987, for a review of this literature). In this study, three-quarters of the children evidenced symptoms that placed them in the clinical range (above the 90th percentile) on a well-known measure of child behavior problems (the Child Behavior Checklist). Although several previous studies have suggested that abuse by a father or father-figure results in more trauma for the child, children in this study who had been abused by another relative or caretaker exhibited more symptoms than those abused by fathers/father-figures. A separate measure of symptoms, completed by the children's therapists, underscored the precarious behavioral status of sexually abused children. Among the most common symptoms reported were: isolation, shame, facade of well-being, and vulnerability.

Specialized sexual abuse treatment programs routinely provide services for the mothers of victims because the deleterious effects of abuse can be mediated by parental support (Kolko, 1987). When victims in the present study were asked to identify sources of support in their lives, the younger children reported that they turned to their mothers for support more than twice as much as did the adolescents, who turned more to their friends.

The support patterns utilized by the victims was found to be related to other factors. Younger children, who reported that

they experienced their lives more out of their control, experienced depressive symptoms, and turned more often to their mothers for support. Children with fewer depressive symptoms turned more often to their friends for support.

It seems axiomatic that child victims of sexual abuse feel helpless and powerless in the face of adult coercion. It appears likely, therefore, that they would also view events in general as not being entirely contingent upon their own behavior and actions, i.e., they would tend to have a more external locus of control. Locus of control also was found to be related to patterns of support for the victims in this study. Adolescents with more internal locus of control turned more often to their mothers. The more adolescents had someone to turn to with their problems, the more they felt like their lives were in their control.

Sexual victimization of the mothers in their own childhoods seems to affect their parenting styles and attitudes in adulthood. Mothers with a history of sexual victimization in their own childhoods had more inappropriate role expectations for their children than those mothers who did not report earlier victimization. These mothers also indicated that they felt their lives were less in their control than mothers who were not abused in childhood.

The problems experienced by the mothers of the sexually abused children, that were most often identified by their therapists, included the feeling of guilt for not protecting the child, feelings of inadequacy as a mother, and feeling helpless in dealing with life's problems.

Evidence of inappropriate role expectations of children was found for more than half of the mothers in the study, indicating a tendency to treat children as confidants or peers, and to use their children to meet their own needs. Mothers with high "role reversal" also reported that they turn to their children for social support more than mothers who had low "role reversal." Mothers with more appropriate role expectations reported that they felt that events in their lives were more under their control.

The availability of a network of friends and relatives as supports to mothers was found to be a very important influence on their lives. Mothers who were able to turn more to their friends and relatives for support scored higher on a measure of parental empathy toward children. Mothers, who had more friends and relatives to turn to, and who turned to them frequently for support, perceived their lives to be more under their control. Finally, the more mothers were able to turn to their own friends for support, the more their children turned to them for nurturance.

A number of other striking similarities were found between characteristics of the sexually abused children and their mothers. Mothers who felt that events were out of control in their lives had children who felt less in control over their lives, and who exhibited more symptoms than other children. Adolescent children of mothers who felt more out of control of their lives tended to turn to them less for nurturance and support.

Similarly, mothers who reported low empathy toward children

had children who turned to them less for nurturance and support, felt less in control over their lives, and exhibited more behavioral problems.

The appropriateness of role expectations held by mothers was also related to their adolescent children's nurturance and behavior. Adolescent children of mothers with inappropriate role expectations turned to their mothers less for nurturance and support, and exhibited more "acting-out" behavioral symptoms.

B. PSYCHOTHERAPY CONTENT, INTERVENTIONS, AND GOALS

The extent to which the experience of sexual abuse should be directly discussed in the therapy of child victims has been a matter of some debate in the field (Burgess, Holmstrom & McCausland, 1978; Borgman, 1984). The data from this study make it clear that the therapists did focus on the nature and impact of the abuse experience in their work with both young children and adolescents. Moreover, the popular wisdom (Mzarek, 1981) that groups provide a safer forum for discussion of abuse-related topics was borne out in this study, as sexual abuse was discussed far more often in group therapy than in individual therapy (although sexual abuse was the most frequently discussed topic, regardless of modality). Issues pertaining to the abuse were discussed more often in the therapy sessions of victims who were anxious or withdrawn, or felt that they had little control over events in their lives.

If discussion of the abuse is in fact important for the success of therapy with children, the evidence from this study is that the more time that elapses between the last (known) incident

of abuse and the start of treatment, the less likely it is that therapy will focus on the sexual abuse, i.e., the more the child and therapist will discuss other matters. The implications for referral are obvious: the sexual abuse will be dealt with more directly in therapy if it is a recent experience.

On the other hand, some clinicians (Mzarek, 1981) have complained that therapy all too often focuses on the abuse, to the exclusion of the family dynamics. In this study, family dynamics pertaining directly to protective issues (including sexual abuse) were not frequent topics of conversation in the therapy of child victims; broader family issues (communication and conflict between family members, methods of handling problems, etc.) were fairly frequent topics, however. And, when family conflicts were related to sexual abuse, therapists worked to help children see how those conflicts might be heightened by the abuse experience.

In terms of methods and modalities, the data from this study make it clear that the therapists used generally acknowledged (if not empirically proven) standards of practice in the treatment of child victims. First, they made early and continued efforts to elicit information about the child's perceptions of and reactions to the abuse (Salter, 1982). Second, they used play therapy with young victims to encourage trust, facilitate the expression of guilt and anger, and foster body awareness (Kelley, 1984; Long, 1986). Third, they used structured group techniques (role plays, modeling and rehearsal, task assignments, etc.) to help members develop or improve their social skills, and overcome their sense of "differentness." Some of these groups were time-limited, and

structured around certain abuse-related "themes" (Sturkie, 1983;, Hazzard, King, & Webb, 1986). Finally, therapists used structured groups to provide normative, and other "objective" information to members, in order to correct cognitive distortions of the abuse experience. Therapists seemed to vary their interventions according to the characteristics of individual cases; for example, they tended to use more supportive approaches with children who had been abused by father or father figures and be more directive with children who exhibited more aggressive or acting-out symptoms.

In terms of the immediate objectives that serve to guide the therapists' choice of treatment interventions, most often, the therapists interventions were determined either by their own need to understand the child and his or her situation, or their purposes in helping the child feel supported and understood. Education was not frequently mentioned as a treatment goal by the clinicians in the study, although groups were used as natural "learning" settings (where cognitive distortions were corrected or information was imparted). Nor was empowerment often cited as an objective, although a prior survey (Deveney, et al., 1986) had indicated that therapists felt it was of utmost importance that child victims learn that they can set limits on others and exert control over their lives. (The therapists in the study did occasionally empower group members to make decisions about the content and focus of sessions, however.) The child's deeper understanding of the impact of abuse (or other issues) on his or her thoughts, feelings and behaviors was also not often cited as an intervention goal nor were interventions frequently made so

that the child might give voice to underlying feelings.

Although maternal support is of vital importance to the well-being of the victim, fewer than half of the mothers in this study were themselves in treatment. Many, in fact, met only occasionally with the children's therapist for purposes of discussing the child's progress in therapy, or behavior at home. For those who did receive treatment on a regular basis, the therapists utilized both individual and group modalities. Family and parenting issues, discussion of the sexual abuse, and issues concerning the therapy itself (modalities, termination, etc.) comprised the bulk of critical material in the therapy of the mothers. Protective issues (safety, boundaries, role expectation, etc.), were critical topics of therapy more often with mothers who found it difficult to empathize with their children. More of the therapy of mothers who felt powerless or had inappropriate expectations of their children focused on the mothers' self-experiences such as anxieties, worries, and fears.

Overall, therapists were not as directive with the mothers as they were with their children but did offer more commentary in the form of reflecting, confronting and reframing. As with children, therapists rarely attempted to interpret mothers actions and motives.

The goals of therapy for mothers were remarkably similar to the aims of therapy with children. The largest proportion of the interventions made in the therapy of both mothers and children were done with the goal of assessment or enhancing the therapist's understanding of the case. This assessment function comprised even a larger portion of the therapy of mothers than

with children. Goals concerning the therapeutic relationship (making the client feel more comfortable in therapy, planning for termination, etc.) were less prevalent in the therapy of mothers. All other therapeutic intentions (support, insight, improving functioning, catharsis, education, and empowerment) were cited in very similar proportions by therapists of mothers and children. As with children, the goal of empowerment and mastery was surprisingly infrequent.

C. FUNCTIONING AT POST-TEST

The children and adolescent victims who participated in this study showed a significant reduction in their behavioral symptoms during the period of time their treatment was followed for this study. This was found with two independent means of measuring behavior problems (the CBCL and the Child Symptom Checklist) with two different informants (mother and therapists). There was no significant change in the victims' sense of control over events in their lives during the study period. While no significant increase was seen in the ability of the victim to turn to her mother for nurturance and support, there was a tendency toward an overall increase in the availability of support to the child, that is, a reduction of occasions when children reported they had no one to turn to for support.

A significant improvement took place in the level of role reversal by the mothers who participated in the study. By the end of the study, the mothers as a group had attitudes about expectations of their children which were much closer to those of mothers in the general population. This decrease in role

reversal was indicated by two methods and by two informants. In addition to the mothers filling out the AAPI about their attitudes regarding parenting, the therapists registered a reduction of parentification of the children when filling out the Child Symptom Checklist.

No changes, however, were found regarding the mothers' sense of mastery, empathy for the child, or in their social support networks.

Many fewer changes were observed between administrations of the pre- and post-tests than were anticipated. The absence of changes on the locus of control and mastery studies may be the result of several factors. One possible explanation is that the sexual abuse is one problem in a pattern of dysfunction in these families, and that the continued disruption in the family may contribute to an ongoing sense that the problems of life are beyond control for victims and their mothers. Compounding the situation may be the fact that criminal justice system procedures continued throughout the first year following disclosure for many of the subjects in this study. This ongoing court involvement, at times lengthened by delays, often keeps the traumatic material alive and impedes children and families from moving beyond the experience. It is also likely that closure of the study after one year may not have been sufficient time to address the mastery and locus of control issues.

The analysis of the psychotherapy interviews may shed some light on the results obtained. While Mastery and Empowerment were among the least frequent intentions, improving parenting skills was one of the more frequent intentions reported by

therapists. Although it was thought that most sexual abuse therapists consider improvements in mastery and empowerment as a primary goal in their work with victims and mothers, it appears that during the first year of treatment, as recorded in the present study, this goal may not be given priority over other important aims. The major demonstrated intentions of the therapists were enhancing their understanding of the case and assessing protective issues. To this end they may not have gotten to issues of mastery and locus of control.

C. IMPLICATIONS FOR TREATMENT

It is striking to note the important role mothers play in their children's recovery. The findings show that children, who felt more in control of their lives and could turn to their mothers for support and nurturance, had mothers who experienced more control over events in their lives, had greater empathy for their children, and had relatives and friends available for support. It could be argued that through the identification process, children whose mothers functioned better socially and emotionally, tended to function better themselves. These findings suggest that an important component in treating sexually abused children is providing therapy, concomitantly, for the children's mothers. Not only does their support help mediate the trauma, but a shift in their attitudes towards more age-appropriate role expectations of their children coincided with a

significant reduction in the children's behavioral symptomatology.

An analysis of the topics discussed in therapy and interventions employed by therapists in a variety of treatment modalities indicate the importance of groups in treating victims and mothers. The findings show that issues pertaining to the sexual abuse experience were more frequently addressed in children and adolescent groups than in individual therapy. This study was not able to report findings on group therapy for mothers since data were collected on only one mothers' group. However, for mothers of sexually victimized children, group treatment can be helpful in several ways: (1) building their social support networks in order to decrease reliance on children and reduce sense of social isolation and stigma; (2) ameliorating feelings of guilt, anger, helplessness, inadequacy and loss through identification with and support from other mothers; (3) encouraging members to help and learn from one another in an effort to build self-esteem and promote movement towards a stronger internal locus of control. As noted above, helping mothers feel better about themselves also benefits their children.

The findings of this study also underscore the importance of treating victims and their families soon after the disclosure of sexual abuse. The longer the time lapse between the last incident of abuse and the onset of therapy, the less frequently sexual abuse issues emerge as a topic in therapy. It may be that a longer time lapse allows for repression of painful material. This may create a dilemma for both the victim and the therapist

since it may be unclear whether to support the child's or adolescent's defenses and avoid unearthing repressed material or to inquire further about the abuse and its effects in the hopes of reworking and resolving the trauma.

Although experienced clinicians reported that empowerment and education are principle goals in the treatment of sexually victimized children and their mothers (Deveney et al, 1986), the data from this study indicated that a relatively small percentage of critical incidents were directed towards these treatment goals. These data seem to contradict what is thought to be common practice in sexual abuse treatment. There are a number of possible explanations to account for this discrepancy.

Since more than half of the cases were still in treatment at at the time of post-testing, it may be that the goal of empowering the victims and their mothers were not yet realized. During the data collection period, considerable emphasis had been placed on monitoring the family situation as evidenced by the high frequency of the therapists' "intentions" of "enhancing their understanding of the case" and "improving parental functioning." This may speak to the ongoing need to assess protective issues and parent-child problems. Quite possibly, the frequent delays observed in the criminal justice proceedings may also contribute to keeping the abuse issues active in a way that impedes stabilization of the family. Consequently, it may be that the stated goals of empowerment and mastery are more long term and less immediate than those of assessment and improving parent's functioning. Had the data collection continued for

another year, these other intentions may have figured more prominently.

It was also not uncommon to find that the sexual abuse was only one of many problems facing the victims and their families. Although these families entered treatment around the sexual abuse, other issues emerged such as: alcohol and drug abuse, neglect, financial struggles, delayed court proceedings, etc. The multi-layering of problems often results in a lengthy treatment process aimed at attending to protective, familial and individual concerns. Over half of the cases in this study tended to be long term, resulting in fewer turnovers for the therapists involved and longer wait lists at the treatment programs.

The findings of this study reinforce much of what has been observed in the clinical arena, namely: (1) utilization of a multimodal approach in treating sexually victimized children and their families; (2) the importance of maintaining the availability of treatment programs to provide services to families during the crisis period, rather than months later when rigid defensive structures may already in place to preserve the homeostasis; (3) treatment of victims and their families is often a long term process (greater than one year) since many cases involve multi-problem families experiencing tremendous instability and stress, both internally and externally.

D. IMPLICATIONS FOR FUTURE RESEARCH

A number of methodological problems interfered with the ability to carry out the stated goals of this research project. Primary among these were the difficulties in recruiting subjects. Projections of potential subjects were based on erroneous assumptions. Future researchers into sexual abuse treatment should plan to recruit two to three times more subjects than they need. Recruitment errors are difficult to correct once the research enters the data collection phase.

Measurement proved to be another problem in this study. With the exception of the Child Behavior Checklist and the Social Support Questionnaire, the instruments used as pre and post test measures should be carefully evaluated. It is suggested that future studies employ measures that are more widely used, and normed on various populations. A control group is also suggested, as it was not possible for us to determine if the mothers in this group had more or less social support at the start than other groups of mothers.

The methodology for recording, coding, and analyzing clinical material from the psychotherapeutic treatment was found to be useful, reliable, and relatively valid. While refinements can and should be made, it appears to have been a practical way of looking into the complicated processes of psychotherapy in a relatively non-intrusive manner.

Future studies which examine the treatment of sexually victimized children should consider collecting data on the treatment for a longer period of time. When data collection

ended on this study, over half of the children and mothers were still actively involved in the treatment process. Since changes over time were noted (the decrease in the topic of sexual abuse), it may be that much of the important work occurs in these cases after their first year in treatment.

Finally, a number of questions remain about the psychotherapy of children, who have been sexually abused, and their mothers. The goals which were stated by a number of experienced therapists in the past did not seem to be the goals in the specific cases in this study, carried out by a different set of therapists. While it may be that the ideas have changed about the goals of treatment in sexual abuse, it appears that the demands of treatment necessitate postponing some goals for the sake of the more immediate needs of the case or client.

REFERENCES

Achenbach, T. & Edelbrock, C. (1983). Manual for the child behavior checklist and revised behavior profile. Burlington, VT: University of Vermont, Department of Psychiatry.

Bachrach, R., Huesmann, L., & Peterson, R. (1977). The relation between locus of control and the development of moral judgment. Child Development, 48, 1340-1352.

Barrera, M. (1981). Social support in the adjustment of pregnant adolescents. In B. Gottlieb (Ed.), Social networks and social support (pp. 69-95). Beverly Hills: Sage.

Bavolek, S. (1984). Handbook for the adult-adolescent parenting inventory.. Eau Clare: WI: Family Development Resources.

Belle, D. (1979). Social links and social support. In Lives in Stress: A context for Depression. Cambridge, MA: Stress and Families Project.

Belle, D. (1982). Lives in stress: Women and depression. Beverly Hills: Sage.

Bialer, I. (1961). Conceptualization of success and failure in mentally retarded and normal children. Journal of Personality, 29; 303-320.

Borgman, R. (1984). Problems of sexually abused girls and their treatment. Social Casework: Journal of Contemporary Social Work, 65, 182-186.

Browne, A. & Finkelhor, D. (1985). The impact of child sexual abuse: a review of the research. (Grant No. MH 15161). Washington, DC: National Institute of Mental Health & (Grant No. 90 CA 0936/01) Washington, DC: National Center for Child Abuse and Neglect.

Burgess, A., Holmstrom, L., & McCausland, M. (1978). Counseling young victims and their families. In A. Burgess, A. Groth, L. Holmstrom, & S. Srgoi, (Eds). Sexual Assault of Children and Adolescents. Lexington, MA: Lexington Books.

Ciccinelli, L., Keller, R., & Gardner, D. (1987). Characteristics of child sexual abuse treatment programs. Lakewood, CO: Applied Research Associates, Inc., Social Systems Division.

Cohen, J. (1960). A coefficient of agreement for nominal scales. Educational and Psychological Measurement,, 20, 37-46.

Conte, J. & Schuerman, J. (1986). Factors associated with an increased impact of child sexual abuse. (Grant No. MH 37133). Washington, DC: National Center for Prevention and Control of Rape, National Institute of Mental Health.

Cooke, M. & Kipnis, D. (1986). Influence tactics in psychotherapy. Journal of Consulting and Clinical Psychology, 54, 22-26.

Deveney, W. (1986). [Interviews with therapists]. Unpublished data.

Deveney, W., Edbril, S., Rintell, D., & Katzman, C. (1987). Services to sexually abused children and their families: A preliminary survey (Grant No. 90-CA-1187). Boston, MA: Research, Evaluation and Planning Unit, Department of Social Services.

Elliot, R. (1983). Fitting process research to the practicing psychotherapist. Psychotherapy Theory, Research and Practice, 20(1).

Elliot, R., James, E., Reimschuessel, C., Cislo, D. & Sack, N. (1985). Significant events and the analysis of immediate therapeutic impacts. Psychotherapy, 22, 620-629.

Garabino, J. & Crouter, A. (1978). Defining the community context for parent child relations: The correlates of child maltreatment. Child Development, 50, 601-616.

Gilmor, T. (1978). Locus of control as a mediator of adaptive behavior in children and adolescents. Canadian Psychological Review, 19(1), 1-26.

Gottlieb, B. (1981). The role of individual and social support in preventing child maltreatment. In J. Garabino & S. Stocking (Eds.), Protecting children from abuse and neglect. San Francisco: Jossey-Bass.

Greenberg, L. & Pinsoff, W. (1986). Process Research: Current trends and future perspectives. In L. Greenberg & W. Pinsoff (Eds.), The psychotherapeutic process: A research handbook. New York: Guilford Press.

Hazzard, A., King, E. & Webb, C. (1986). Group therapy with sexually abused adolescent girls. American Journal of Psychotherapy, 40, 213-223.

Hill, C. & O'Grady, R. (1985). A list of therapist intentions: Illustrated in a single case and with therapists of varying theoretical intentions. Journal of Counseling Psychology, 32, 3-22.

Kelley, S. (198). The use of art therapy with sexually abused children. Journal of Psychosocial Nursing, 22, 12-18.

Kolko, D. (1987). Treatment of child sexual abuse: Programs, progress and prospects. Journal of Family Violence, 2(4), 303-318.

Kroth, J. (1979). Child Sexual Abuse: Analysis of a Family Therapy Approach. Springfield, IL: Thomas.

Long, S. (1986). Guidelines for treating young children. In K. MacFarlane & J. Waterman (Eds)., Sexual Abuse of Young Children: Evaluation and Treatment. New York: Guilford Press.

Mahrer , A., & Nadler, W. (1986). Good moments in psychotherapy; A preliminary review, a list and some promising research avenues. Journal of Consulting and Clinical Psychology,

Maidman, F. (Ed.). (1984). Child welfare: A sourcebook of knowledge and practice. New York: Child Welfare League of America.

Milgram, N. (1971). Locus of control in negro and white children at four age levels. Psychological Reports, 29, 459-465.

Mrazek, P. (1981). Group psychotherapy with sexually abused children. In P. Mrazek & C. Kempe, C (Eds.), Sexually Abused Children and Their Families. New York: Pergamon Press.

Nowicki, S. & Strickland, B. (1973). A locus of control scale for children. Journal of Consulting and Clinical Psychology, 40(1), 148-154.

Omizo, M., & Omizo, S., (1987). The effects of eliminating self-defeating behavior of learning disabled children through group counseling. The School Counselor, 34, 282-288.

Orlinsky, D. & Howard, K. (1978). The relation of process to outcome in psychotherapy. In S. Garfield and A. Bergin (Eds.), Handbook of psychotherapy and behavior change: An empirical analysis (2nd ed.,). New York: Wiley.

Pearlin, L., Menaghan, E., Lieberman, M., Mullan, J., (1981). The stress process. Journal of Health and Social Behavior, 33, 337-356.

Rutter, M. (1979). Protective factors in children's responses to stress and disadvantage. in M. Ken & J. Rolf (Eds.), Primary prevention of psychopathology. Vol. III: Social competence in children. Hanover, NH: University Press of New England.

Salter, A. (1988). Treating child sex offenders and victims. Beverly Hills, CA: Sage.

Saunders, E. (1979). The children's views. In Stress and Families Project: Lives in stress: A context for depression , 316-336.

Sturkie, K. (1983). Structured group treatment for sexually abused children. Health and Social Work, 4, 299-309.

Thomlinson, R. (1988). A review of child sexual abuse treatment outcome research. (Project No. 4569-1-244). Calgary: University of Calgary.

Tufts New England Medical Center. (1984). Sexually exploited children: service and research project (Grant No. 80-JN-AX-0001 S-2). Washington, DC: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice.

Wald, M., Carlsmith, J. & Leiderman, P. (1988). Protecting abused and neglected children. Stanford, CA: Stanford University Press.

Walford-Kraemer, P. (1984). Depression and mastery in women: Difference according to personal characteristics. Southern Psychological Reports, 54(3), 710.

Vaux, A., & Harrison, D. (1985). Support network characteristics associated with support satisfaction and perceived support. American Journal of Community Psychology, 13, 245-269.

Vaux, A., Burda, P. , & Stewart, D. (1986). Orientation toward utilizing support resources. Unpublished manuscript, Southern Illinois University.

Zill, N. (1978). Divorce, marital happiness and the mental health of children: Findings from the Foundation for Child Development National Survey of Children. Unpublished report.

APPENDIX A

THE TREATMENT OUTCOME PROJECT
INCLUSION CRITERIA

These guidelines have been written to assist you in determining which of your cases are appropriate for inclusion in the research study. All cases which have been referred to your program in which there is a concern that a child has been sexually abused (whether or not there has been a disclosure) can be included if they meet the following criteria:

- At least one child in the family, aged 6-16, has been referred for evaluation or treatment for sexual abuse or the suspicion of sexual abuse.

- The alleged offender is:
  1. Male
  2. In a "caretaker" role, i.e.,
  Father
  Stepfather
  Live-in boyfriend
  Steady boyfriend
  Uncle (in the case of single-parent families)

- The non-offending parent (usually mother) signs the informed consent for her participation and/or her child's participation.

  Note: It is not necessary for <u>both</u> the mother and her child to participate. If the mother agrees, and her child does not, the mother will be in included in the study and the child will not. If a mother does not wish to participate, she may agree to her child's participation. In cases where DSS has custody, DSS and the parent should be asked to give consent for the child's participation.

- In families with multiple victims, each victim can be included if s/he is between the ages of 6 and 16 (and agrees to participate).

- A child may participate if s/he is living in her family home, or is placed in a foster home or with a relative; if s/he is in the custody of his/her parents, or in the custody of DSS.

If any question arise with regard to whether or not a case can be included in the study, please feel free to contact one of the research staff.

APPENDIX B

Recording Form for Psychotherapy Process

Date __/__/__ Code # _____

Sessions scheduled for month: ____ Sessions Attended: ____
Individual _____ Group _____ Family _____

1. What do you consider to be the most important moment in the therapy hour?

Topic: _____
_____
_____

Activity: _____
_____
_____

Intention: _____
_____
_____

2. What else happened in the hour that you consider to be an important moment?

Topic: _____
_____
_____

Activity: _____
_____
_____

Intention: _____
_____
_____

3. What do you consider to be the most important moment in the therapy hour?

Topic: _____
_____
_____

Activity: _____
_____
_____

Intention: _____
_____
_____

APPENDIX C

Psychotherapy Critical Event Coding Categories

---------- Topics ----------

1. SEXUAL ABUSE

Any reference to actual sexual abuse, past or present: Offender, experience of abuse, court proceedings, etc. This includes a mother's history of sexual abuse as a child. It does not include suspected abuse, which is coded #2, protective issues.

2. PROTECTIVE ISSUES/BOUNDARIES

a) Protective and safety issues.
   Includes living arrangements when in regard to safety.
   Suicidal acts, Physical abuse issues, family violence.
   (Suicidal ideation is coded #6).
b) Out of home placement, such as foster care
c) Boundaries, personal/family, inappropriate role expectations
d) Suspected sexual abuse, past or present

3. THE THERAPY AND THE THERAPIST

a) Topics that deal with aspects of therapy and the therapeutic relationship. Modalities, termination, ...
b) Relationships and interaction between group members.

4. FAMILY ISSUES

a) Parenting
b) Family issues with parents, children, relatives, living arrangements with family members which do not involve protective issues. Mother's live-in boyfriends should be included.

5. LIVING IN THE WORLD

Relationships with friends, peers, boyfriends of adolescents, neighbors; at work, at school. Concerns about money unrelated to therapy payment.

6. EXPERIENCE OF THE SELF

a) Dreams, fears, fantasies, feelings, anxiety, worries, thoughts about the future, suicidal ideation. (Suicidal acts should be coded #2, protective issues).
b) Body function, health and appearance
c) Sexuality, non-abusive

7. SILENCE, NON-VERBAL ACTIVITY, PLAY

Periods of silence, play which does not have another topic as its focus.

---------- Therapist Activity ----------

1. DIRECTING

Offering advice, suggesting options/response/actions, limit setting, making/enforcing a rule, assigning task/homework, contracting, giving explicit directions, modeling, role-playing, playing therapeutic games, asking group or family members to interact.

2. MAKING CONNECTIONS

Interpretations (bringing unconscious material to consciousness), making connections between events/thoughts/feelings of client and/or other.

3. ASKING FOR CLIENT'S PERCEPTIONS

Inquiries about client's perceptions and feelings about self or others. Usually but not always in the form of a question asked by the therapist. If asking for factual information, code #6.

4. REINFORCEMENT/SUPPORTIVE COMMENTARY

Praising, supporting, reinforcing a thought/feeling/action. Conveying empathy, sympathy, reassurance. Letting client know that therapist understands.

5. INFORMING

a) Giving normative data to client
b) Correcting cognitive distortion, "Reality Testing".
c) Providing information.
d) Therapist self disclosure

6. INFORMATION SEEKING

Obtaining factual information from client (as distinguished from obtaining the client's perceptions/feelings/reactions).

7. LISTENING, REMAINING SILENT

Sitting attentively with client, non-verbal cuing which attempt to encourage client to proceed, conveying empathy non-verbally, just being silent and waiting, playing silently with client.

8. COMMENTARY ON CLIENT'S THOUGHTS/ACTIONS FEELINGS

a) reflection: restatement or rephrasing of client's statements
b) confrontation: pointing out that a client's thoughts or actions are contradictory, conflicting, or non-functional; comments aimed at changing the way client sees situation:
c) reframing, paradoxical intention, therapist commentary: therapist's comments and observations about the client's behavior.
d) Changing/maintaining the focus: attempt by the therapist to focus discussion.

---------- INTENTIONS ----------

1. EDUCATION/UNDERSTANDING OTHERS

a) Providing information to client, offering explanations, and correcting misconceptions.
b) Improving client's understanding of the behavior and motivations of others. (If other is child of client, and goal is related to parenting skills, code # 7).

2. SUPPORT

Conveying to client that she is being heard and understood, validating client's experience/feelings, providing a "holding environment", reinforcing good work. (If therapist is being supportive of empowerment/mastery, code #4).

3. INSIGHT/SELF UNDERSTANDING

Increasing the client's self-understanding. Helping client understand her feelings/thoughts/actions, helping client understand the connection between past and present, action and feeling, patterns, etc., bringing unconscious motivations to consciousness.

4. EMPOWERMENT/MASTERY/CONTROL

Helping client attain greater control over her life, and experience self in control. Attempts to build a sense of mastery. Reinforcement of client's growing sense of empowerment.

5. CATHARSIS

Facilitating expression of affect with no other stated goal.

6. MAINTAINING /IMPROVING THE THERAPEUTIC ALLIANCE

Goals relating to conducting the therapy itself. Included are attempts to keep client in treatment, attempts to have a good termination, making client more comfortable in therapy.

7. IMPROVING INDIVIDUAL, FAMILY, AND SOCIAL FUNCTIONING

a) Individual: Increasing client's coping skills, improving client's ability to communicate. Building "ego strength, enhancing self-esteem. Strengthen defenses, reduce anxiety.
b) Family: building boundaries/differentiation of self and other, improving parenting skills, improving ability to protect child.
c) Expanding client's social network.

8. ENHANCE THERAPIST'S UNDERSTANDING OF CASE/ASSESSMENT

Eliciting information from client which is not codeable above. Includes protective monitoring by therapist, gathering information about a client's reactions/ideas/thoughts/feelings, attempts to "find out".

APPENDIX D
Validity Study

PART A

Part A was intended to establish the content validity of the coding categories of the Critical Event Measure. The judges were given descriptions of the coding categories for topics, activities and intentions. Judges were asked to rate on a 7-point scale the comprehensiveness of the categories as descriptors of the psychotherapy of sexually abused children and their families and to rate the extent to which the definitions of the coding categories fit with their prior understanding of the construct.

Results:

The mean ratings are as follows:

1. Comprehensiveness of categories (1=Not comprehensive, 7=Totally comprehensive):
   $\bar{x}$=6.33
2. Extent that categories fit with prior understanding of construct (1=not at all close, 7=extremely close):
   Topic: $\bar{x}$ = 6.00
   Activity: $\bar{x}$ = 6.00
   Intention: $\bar{x}$ = 6.33

PART B

Part B of the validity study was also intended to provide content validity of the coding categories. The experts were presented with a series of ten topic, activity and intention statements which had been randomly selected and coded by the researchers. The judges were asked to rate on a 5-point scale the extent to which they agreed or disagreed that the statement belonged in the category specified.

Results

The following are the mean expert judgment scores for the three categories of codes:

Topics: $\bar{x}$ = 4.53
Activities: $\bar{x}$ = 4.53
Intentions: $\bar{x}$ = 4.66

PART C:

Part C was intended to provide construct validity. In Part C of the validity study, the experts were asked to code thirty critical incidents which were selected at random from the data base. Their task was to use the coding system as presented to them. The assigned codes were compared using Cohen's Kappa to each other, and the consensus codes assigned by the researchers.

Results

The coefficient (r value) for each is as follows:

	Interrater Agreement	Agreement with Consensus Codes
Topics	.74	.79
Activities	.72	.64
Intentions	.71	.74

APPENDIX E
DEMOGRAPHIC DATA

VICTIMS

Age of victim at onset of Abuse:

	ENTIRE SAMPLE		ONE SIBLING SAMPLE	
Age	n	%	n	%
1-5	10	29%	8	30%
6-9	9	26%	7	26%
10-13	13	37%	6	22%
unknown	7	20%	6	22%
	35	100%	27	100%
	$\bar{x}$ = 8 years		$\bar{x}$ = 7 years	

Age of victim at beginning of treatment:

	ENTIRE SAMPLE		ONE SIBLING SAMPLE	
Age	n	%	n	%
6-9	6	17%	6	22%
10-13	13	37%	10	37%
14-17	16	46%	11	41%
	35	100%	27	100%
	$\bar{x}$ = 12.5		$\bar{x}$ = 12.0	

Duration:

	ENTIRE SAMPLE		ONE SIBLING SAMPLE	
	n	%	n	%
Single incident	1	3%	1	4%
Less than 6 months	5	14%	4	15%
6 months to 1 year	0	0%	0	0%
1 year to 5 years	16	46%	12	44%
More than 5 years	5	14%	3	11%
Unknown	8	23%	7	26%
	35	100%	27	100%
	$\bar{x}$ = 31 months		$\bar{x}$ = 25 months	

Penetration (Vaginal, Oral or Digital):

	ENTIRE SAMPLE		ONE SIBLING SAMPLE	
	n	%	n	%
Penetrated	23	66%	17	60%
Not penetrated	9	26%	8	30%
Unknown	3	3%	2	7%
	35	100%	27	100%

Relationship of offender to victim:

	ENTIRE SAMPLE n	%	ONE SIBLING SAMPLE n	%
Biological Father	14	40%	10	37%
Stepfather	6	17%	6	22%
Mother's live-in boyfriend	4	11%	3	11%
Other relative	7	20%	4	15%
Non-family member	4	11%	3	11%
	35	100%	27	100%

MOTHERS

Age of mother:

	n	%
Less than 30	6	25%
30 - 39	10	41%
40 - 49	6	25%
Unknown	2	8%
	24	100%

$\bar{x}$ = 35 years

Marital status:

	n	%
Married	10	42%
Divorced or separated	11	45%
Never married	1	4%
Live-in partner	2	8%
	24	100%

Occupation of mother:

	n	%
Unemployed	10	42%
Unskilled	1	4%
Semiskilled	6	25%
Skilled	1	4%
Clerical	2	8%
Manager/Professional	3	12%
Unknown	1	4%
	24	100%

Highest educational level:

	n	%
Less than high school	5	20%
High school	11	46%
Partial college	1	4%
Graduate degree	1	4%
Unknown	6	25%
	24	100%

Family Income:

	n	%
Less than $10,000	8	28%
$10,000 - $19,000	6	21%
$20,000 - $29,000	4	14%
Over $30,000	2	7%
Missing	9	31%
	29	100

$\bar{x}$ = $23,100